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Max Zubatsky
Jackie Williams-Reade *Editors*

Self of the Therapist in Medical Settings

A Sociocultural and Systemic Perspective

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Founded in 1977, the **American Family Therapy Academy** is a non-profit organization of leading family therapy teachers, clinicians, program directors, policymakers, researchers, and social scientists dedicated to advancing systemic thinking and practices for families in their social context.

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AFTA's mission is developing, researching, teaching, and disseminating progressive, just family therapy and family-centered practices and policies.

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Series Editor's Foreword

The AFTA Springer Briefs in Family Therapy is an official publication of the American Family Therapy Academy. Each volume focuses on the practice and policy implications of innovative systemic research and theory in family therapy and allied fields. Our goal is to make information about families and systemic practices in societal contexts widely accessible in a reader-friendly, conversational, and practical style. AFTA's core commitments to equality, social responsibility, and justice are represented in each volume.

In *Self of the Therapist in Medical Settings: A Sociocultural and Systemic Perspective*, Max Zubatsky and Jackie Williams-Reade provide a much-needed guide for mental health providers entering the world of medicine. Drawing on their own experiences and that of their colleagues, they walk readers through medical culture and practices and the unique challenges behavioral healthcare workers face in these settings. Many readers will be like me, with experience in medical settings only as a patient or family member. Working in this context feels intimidating and confusing, and the practices learned in behavioral health professions often don't fit. Zubatsky and Williams-Reade help readers find their own worth and value in medical settings while demystifying the medical culture. Their practical "dos and don'ts" inspire confidence that one can negotiate this new terrain.

The book calls readers to be self-reflective and examine themselves, anticipating and normalizing personal responses and emotions that will come into play. Several chapters illustrate how our own experiences with healthcare and our social locations (race, gender, etc.) intersect when working as part of a collaborative healthcare team. The book is both optimistic and realistic. It will undoubtedly be required reading for family therapists and other mental health professionals taking their first steps into the challenging and rewarding work in medical settings. It will also be useful to supervisors and colleagues who want to understand and support them. Whether entering the medical world or learning about it, the readers will be inspired and increase their appreciation for this important work.

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Lewis & Clark College,
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Carmen Knudson-Martin

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Preface

As healthcare continues to expand the need for mental health services, therapists are assuming greater presence to provide care to patients and families. Behavioral Health Professionals (BHPs) are being recognized as key providers on integrated care teams and in secondary and tertiary care settings such as endocrinology, pain clinics, geriatrics, and pediatrics. As a result, more graduate programs are teaching basic medical topics, psychopharmacology, and collaborative skills to help integrate new professionals in the field. However, clinicians often find that their personal beliefs, biases, and challenges are often the most difficult barriers to address when working in these settings.

When researching the literature on self-of-the-therapist topics and curriculum, the options out there were much more limited than we had anticipated. The topic comes up so much in training and graduate coursework, yet very few resources address the "real-life" struggles that new (and even seasoned) professionals experience. In our current faculty roles, we hear many personal issues, stories, and reactions of students and new professionals working in the world of medicine. The challenges do not just pertain to the conditions of patients and families but the operational systemic and ecological issues that can impact the care that clinicians provide in these settings. These underlying factors not only play a significant part in how new students, interns, and trainees work with patients but also attend to areas that may activate their own social and cultural experiences.

The development of this volume for us really came out of three impactful experiences. The first was out of an assignment in the Medical Family Therapy Program at Saint Louis University taught by Max. One course on theories and models of Medical Family Therapy requires students to put together a "Self of the Medical Family Therapist" presentation for their colleagues. The student presents a medical issue that either they or another family/close friend has experienced. In the four years of hearing these talks, the depth of vulnerability, new perspectives on culture and spirituality, and personal narratives of the meanings of illness is truly remarkable. It has not only strengthened the trust between each graduate cohort but helps students bring their guard down around illness and disability when working in clinics.

The second influence came out of a similar course and assignment taught by Jackie at Loma Linda University. In her Medical Family Therapy class, students complete a health and illness genogram which traces the transgenerational impact of illness in their lives. These presentations always bring significant revelations to students regarding the often "invisible" role illness plays in their lives. In addition to these insights, Jackie noticed that students' personal stories often intersected with challenges they experienced when providing therapy to patients and families and/or interacting with medical professionals. It became apparent that students' personal experiences were often clouding their abilities to work therapeutically and collaborate effectively. Working with students on these personal responses present in their professional work can be tricky, so writing a volume on these issues can help guide this conversation.

The final impact for this book was through conversations with training students and new professionals at different conferences. We noticed a large gap in the "self-of-the-therapist" training that students and interns encounter in integrated care settings. The field was assuming that new mental health professionals could seamlessly transition into these settings with ease. Hearing the need for more seminars at the Collaborative Family Healthcare Conference on this topic only furthered our curiosity into this area. As a result, the need to develop a guiding text for new professionals was apparent.

This brief can help serve as a valuable resource in mental health and integrated care training for several reasons. First, there is a lack of literature on how the "person" of the therapist is developed in medical training. When many mental health professionals take a biopsychosocial framework into practice, they not only see a more holistic perspective of patient care but also face challenges that cause them to take an introspective look at their own influences and orientation in providing care in a medical system. Second, unlike private practice and many for-profit clinics, medical settings may offer unique challenges and opportunities that therapists often do not anticipate and require new skillsets. For instance, outside of typical clinical duties, there are also operational and financial considerations that mental health professionals may be expected to address when working with underserved populations. Third, there are often unexamined beliefs and biases that therapists may hold about patients, families, medical professionals, and illness at large. Engaging in clinical care requires a reflexive process that looks more closely at one's self, patient and family perspectives, professional values, ethics, and medical culture.

This volume is a starting point for mental health professionals who are looking for self-of-therapist training as they begin their clinical work in a healthcare setting. Several chapters will highlight some of the important yet often unspoken topics that impact the type of care therapists provide to patients and families across a range of diagnoses. Sections will also address how issues such as personal experience with illness, cultural differences, professional burnout, stigma, and differing ethical perspectives of care may impact how professionals work in everyday practice. The last chapter serves as a unique insight into the "self" experiences of seasoned professionals and what advice they offer to the future workforce.

There are some disclaimers that we want to mention from the beginning. First, the concepts, findings, recommendations, and case studies come largely from western cultures of the world. As therapists are assuming more roles in healthcare settings globally, we should also consider the cultural variations seen in behavioral health practice across different countries. Second, we use the terms "medical family therapist" and "behavioral health provider" as overarching roles of mental health professionals in medical settings. There are several mental health disciplines that represent the scope of providers working in medicine. These two terms represent a mental health professional that views a biopsychosocial, systems framework in practice and routinely collaborates with other medical professionals for the care of patients and families. Third, both editors are white academics, where we needed to continually be aware of the power and privilege when explaining certain cultural themes and content. We wanted to be very transparent in how our "self" was impacted through a variety of training and practice situations in healthcare. Our plan to bring diverse authors onto our last chapter of the book was to expand the knowledge and advice that this resource can provide to readers.

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Acknowledgments

Max Zubatsky First, I want to thank my coeditor, Jackie Williams-Reade, for agreeing to write on this important topic for behavioral health professionals. Jackie has not only been a great colleague but a wonderful leader in the field around self-of-the-therapist topics though her teaching, research, and clinical work. Her insights and perspectives in this area were invaluable to making this book an important resource to future professionals in medicine.

I also want to thank my family who has supported me through my journey as a student and professional. My parents have given me the advice to always be authentic in both my work and my personal life. Their knowledge has greatly impacted the authenticity I strive to provide to my patients and families in practice. Over the last decade, there have been several life and medical events in my family that have shaped my perspectives of patient care, family resiliency, caregiving, bonding of family members, and spirituality. These situations impacted not only my emotional "self" but my work-life balance at different points of my career. I have been a human and a family member a lot longer than I've been a therapist. Therefore, much of this book was inspired by the personal aspects that impacted my training and emergence as a provider in medicine.

Finally, I want to thank the wonderful students and residents that I have taught over the years. Through many course assignments, clinical rotations, and process groups, I have learned so much from them about the human side of the provider and the similar challenges we all face during very difficult situations. Their authenticity and vulnerability made me realize how valuable we all are to the healthcare system. My hope is that this book is a "pay-it-forward" to future instructors, supervisors, and mentors who can consistently emphasize the use of "self" in their clinical work.

Jackie Williams-Reade I would like to first thank Max Zubatsky for inviting me to be a part of this exciting project. Writing a book has been a goal of mine for several years, and I am grateful to have had the chance to make it a reality on a topic that I am passionate about alongside a valued colleague.

I always think of the phrase "It takes a village" when I think of Medical Family Therapy (MedFT) because it requires so much collaboration and energy to bring

about good outcomes. My becoming a MedFT is due to a village of people helping me along the way – family members, patients, colleagues, students, and professors. There are too many to mention, but I'll say a few here. Much of the writing required me to revisit some challenging times in my life due to illness. I must thank my grandma, Doris Williams, for her loving presence in my life in general and throughout the illness and death of my grandpa, Waldo, from pancreatic cancer. His death inspired me to give back to the medical community that supported our family during that time and led me to work in pediatric oncology for several years. For the children, parents, and colleagues I met during that time, thank you for teaching me how to walk alongside those who experience deep suffering. Also, to my MedFT teachers, including professors, patients/clients, colleagues, and students, thank you for the ways you have challenged and supported me along the way to see the impact of illness more clearly and find ways to attend to what I see. And to you the reader, I hope this book helps you feel understood and also challenges you to think differently about yourself and your role as part of the medical team. Thank you for picking up this book and being willing to do the difficult self-of-therapist work that is so important in working with patients and families facing illness.

Both Editors We would like to thank the series editor, Carmen Knudson-Martin, for her continual support and guidance in the process of this book. We are so grateful for her vision and helping to usher us through the process with Springer. She has also given us great freedom to explore the numerous multicultural and systemic issues that impact our work on a regular basis. Additionally, we want to thank Tai Mendenhall for his valuable role as guest editor for the chapters and dedication to help in the editing process for this book. His background as both a clinician in Medical Family Therapy and a writer for learners in medical settings was such a valuable resource in helping us convey this content to our audience.

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About the Editors

Max Zubatsky, PhD is an Associate Professor and Program Director of the Medical Family Therapy Program at Saint Louis University. He is a Licensed Marriage and Family Therapist and State-Approved Supervisor. He completed his doctorate at the University of Minnesota in Family Social Science and his postdoctoral fellowship at the Chicago Center for Family Health. His research interests include geriatrics, caregiving, integrated behavioral health, behavioral health skills of family medicine residents, and provider well-being. He currently directs The Memory Clinic, a specialty clinic in the Center for Counseling and Family Therapy which provides individual and group services to patients and families with memory loss. Max is the Coordinator of Integrated Behavioral Health in the Department of Family and Community Medicine and teaches courses to master's, doctoral, and medical students in several clinical and research areas. He has published over 20 chapters and articles on mental health and medical topics in the field.

Jackie Williams-Reade, PhD is an Associate Professor at Loma Linda University in Loma Linda, CA, where she trains and supervises students in integrated care, conducts and supervises research, and presents nationally on topics related to families and health. She completed her doctorate in Medical Family Therapy from East Carolina University and her postdoctoral fellowship in pediatric palliative care at Johns Hopkins University. Her research interests include the application and advancement of Medical Family Therapy, pediatric illness, utilizing qualitative research to privilege patient and family voices in healthcare, meaning-making and spirituality, and self-of-therapist issues in medical settings. She has over 20 publications, has presented numerous times nationally and internationally on Medical Family Therapy, she is the Administrator of the 600+ member Medical Family Therapy Group on Facebook, and is the founding chair of the Family Therapists in Healthcare Interest Network with the American Association for Marriage and Family Therapy.

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Navigating the Culture and Context of Medicine

Max Zubatsky and Jackie Williams-Reade

Entering the world of medicine for the first time is almost the equivalent to being dropped in the middle of an Amazon rainforest. There is no compass, no guide map, and no one to hold your hand to navigate a new territory. The journey requires instincts and the flexibility to be open to the unknown. The experience can be incredibly rewarding yet pulls at many personal and professional challenges of new clinicians. Many of these challenges not only arise in one's professional work but also trigger unexpected areas in one's personal life as well.

Take, for example, a hospitalized patient who is diagnosed with end-stage renal failure, where their breathing capacity is extremely low. The family of the patient has been visiting and talking to the daughter, who is the primary healthcare power of attorney. Several family members have had disagreements about whether to transition the patient back to their home. The Medical family therapist (MedFT) is brought into an emergency family meeting in one of the corner rooms to consult with the family. With little knowledge or background about the case, the MedFT uses circular questioning, contextual interviewing, and shared language to help the family and therapist agree to the best possible option for the patient in a limited timeframe. This therapist balances these skills, all while facilitating a meeting where members must come to terms with the situation in the best way possible.

Where traditional psychotherapy offices generally provide a comfortable environment for providers and patients to meet, a healthcare setting can often present the therapist with unconventional practice situations. Family meetings may take place

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in a hollow conference room, where overhead pages interrupt the flow of conversation. Brief consultations in the examination room force members to sit in crammed spaces and come near one another. Other providers needing a new room may disrupt the flow of an important conversation between the therapist and family. New interns, trainees, and students must adapt to a different way of providing counseling services. Patient care around certain mental and physical conditions can be just as effective during the 20-minute consultation as the traditional 50-minute psychotherapy appointment. Learning to provide care in shorter timeframes is thereby an important learning curve for trainees to traverse.

Behavioral health is on the cutting edge of providing key services to some of the most vulnerable and underserved populations in healthcare (Cummings, 2016; Doherty, McDaniel & Hepworth, 2014). This chapter will introduce a new world of medicine for beginning behavioral health providers, highlighting some necessary skills and areas to consider regardless of one's practice setting. The biopsychosocial–spiritual approach will be presented in a novel way, applying these aspects not just to patient and family care, but the parts of the "self" that impact the therapist's experience when working in these medical contexts. Specific suggestions on the "Do's and Don'ts" when working on a healthcare team will also be highlighted.

The Landscape of Therapists in Medicine

With the shortage of primary care physicians (PCPs) able to meet the service needs of patients in the United States, unattended mental health needs will be a continued challenge for many of these settings (Blount & Miller, 2009). Because primary care is often seen as the "de facto" setting for mental health screening and diagnosing (Kessler & Stafford, 2008), PCPs will increasingly be demanding the services of behavioral health providers to address this rise. Presently, behavioral health providers (BHPs) are uniquely positioned to address the ongoing health challenges in our system and identify effective opportunities to intervene with families in medicine. Increased areas of patients' social and familial lives that impact their health are primed for BHPs to provide additional services. The emergence of more social determinants of health factors, such as housing, employment, insurance, transportation, and healthcare resources, has also been a large area for BHPs to address. Primary care has acknowledged that these outside factors in patients' lives are affecting not just health outcomes, but the bottom-line revenue of these clinics.

Over the last two decades, both MedFTs and BHPs have provided care for families struggling with a myriad of these diseases in medical settings, such as anorexia nervosa (Cubic & Bluestein, 2008), asthma (Carr, 2009), cancer (Northouse, Katapodi, Song, Zhang, & Mood, 2010), chronic pain (Robinson & Reiter, 2007); Runyan, Schinamann, & O'Donohue, 2008) diabetes (Zubatsky & Mendenhall, 2018), and heart disease (Katon et al., 2010). Additionally, there are opportunities for therapists to work in medical specialties such as rehabilitation medicine, reproductive health, and geriatrics (Hodgson, Lamson, Mendenhall, & Crane, 2014).

Providers are even seeking areas to address community-based issues and needs via groups and action-based services.

The self-of-the-therapist work that professionals are encouraged to address in their graduate training and early career years is largely out of the traditional psychotherapy model of treatment. Certainly, topics such as transference, resistance, family of origin issues, and cultural factors still play a large role in the elements of the "self" in medicine. However, many operational, socioeconomic, political, and social areas of practice settings have been lightly discussed in the training of new behavioral health professionals. These areas are often the blind spots for not just new trainees, but experienced clinicians in practice who do not pick up these issues right away. As a white male (Max) who entered a medical setting in my graduate training for the first time, I had to learn how power, privilege, and cultural differences impacted not only interactions with patients, but my own sense of awareness when acclimating into a new care team. Thus, there are multiple areas in a BHP's training that should attend to the growth of one's "self" over time.

A Biopsychosocial–Spiritual View of the Self in Medicine

Many MedFTs have been trained in the biopsychosocial (BPSS) model of healthcare, which facilitates collaboration with medical professionals and interdisciplinary teams (Becvar & Becvar, 1999; Engel, 1977, 1980). The BPSS approach has been historically seen to view the context of the patient and family system in healthcare and taking a holistic view of a person's health. Clinicians must also attend to the spiritual aspects of a person's health regarding their beliefs on treatment and personal decisions of their healthcare (Wright, Watson & Bell, 1996). Yet, this same framework can be seen in the context of therapists' own reactions and situations when working in a new medical setting. The systemic principles that a patient might benefit from in their care could apply to the dimensions of the BHP working in these environments. Since this framework is the basis of many chapters in this book, it is important to acknowledge the different dimensions of the therapist's "system" that become activated when working with patients and families in these practice contexts (See Fig. 1).

Family therapists may have certain physiological responses to some of the procedures or materials in examination rooms or offices. Those who have significant germ or blood phobias may be challenged from going into rooms or procedural areas where equipment is present. Once must become familiar being around equipment and other medical supplies in rooms while speaking with patients and families. For example, a new trainee is staying in a hospital room while the patient is getting their medication injected. This therapist may have an aversion to needles or blood, which can affect how long they stay in the room or their mindset of continuing to interact with the patient moving forward. Additionally, any personal illnesses that the therapist has or is currently suffering from could impact their attitudes or motivation around particular patients. Often, personal illness may require one to

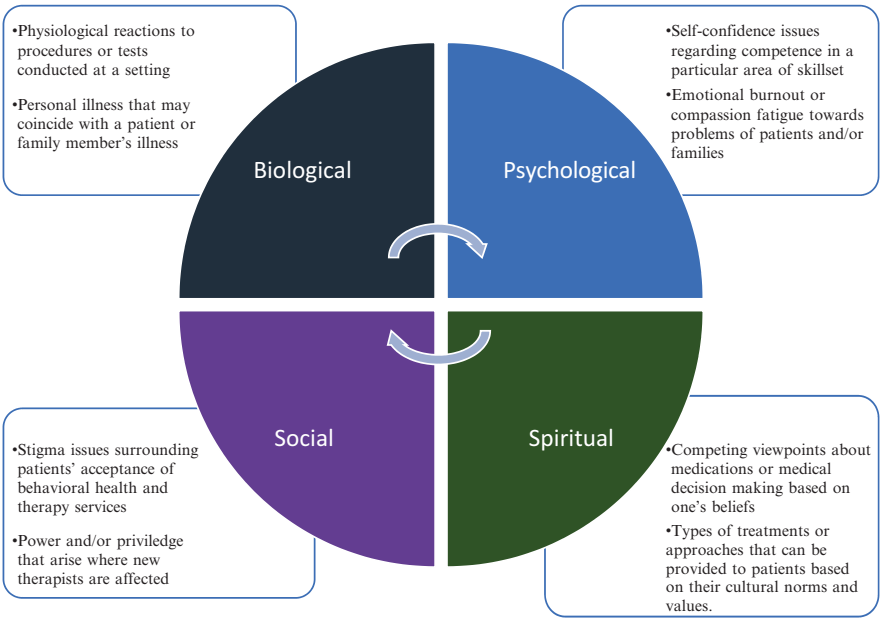

Fig. 1 The biopsychosocial–spiritual elements of the "self" in medical settings

monitor their own health during the day and maintain communication with the attending provider or the supervisor about any complications that might arise.

One might also experience psychological reactions and/or social experiences to issues or topics that arise during encounters in practice. Family of origin issues and/or personal illness (discussed in chapter "Personal Illness and Family of Origin") can often make a new student, intern, or professional feel vulnerable around any number of diagnoses that are either verbalized or charted in medical records. For instance, a MedFT trainee may not agree with a bipolar diagnosis of the patient in their chart, which may largely be due to a misdiagnosis of bipolar of their own family member. This perspective might impact the MedFT in how they interact with the physician who gave this diagnosis to the patient. New therapists may also have a mindset as being the "one-down" provider in a clinic, where the physician and other healthcare team members are playing a larger role. This type of mindset often happens when professionals enter "silo" types of practices (See Professional Identity Chapter), where each field operates in their own section of the clinic, setting, or hospital.

The provider's spirituality might even impact their views on areas such as medications, medical treatments, or family's perspectives on death and dying. Therapists also need to become aware to patients' varying belief systems around their philosophy of health change and health behaviors and learn to honor the patient's perspectives. These competing viewpoints can be difficult for even seasoned BHPs, where the incongruences around treatment options and follow-through of recommendations create frustrations for many. Examples may include herbal remedies to help treat depression instead of anti-depressant medications; resistance to follow-through with back surgery for religious reasons; a patient who wants to do some-

thing (e.g., birth control, a elective procedure), but is not "allowed" to by other family members; or decisions on end-of-life care in the hospital around renal kidney failure. The therapist must learn to first recognize these internal struggles around their own beliefs or biases regarding a patient's decision-making and find areas to work on this growth throughout training.

Strategies for New Therapists Entering Medical Settings

As the saying goes, "When you're getting your Bachelor's, you think you know everything. When you're getting your Master's, you think you know some things. When you're getting your doctorate, you realize you don't know anything." I (Max) was fairly intimidated the first week entering a new practicum position in a University-Based Eating Disorders Clinic. Despite previous master's courses in health topics, a year-long child and family internship, and several site visits to hospitals and clinics, being part of a healthcare team was now a reality. I immediately felt the need to prove my worth. My first medical note read more like a Robert Frost essay that was expanding on the patient's "Road Less Traveled." My introductions to new medical professionals turned into five-minute diatribes that was spanning my entire resume. Quickly, I realized the value of becoming an anthropologist in a new environment, studying the ways that I can and should assimilate into an existing group of providers. Joining a new team involves learning not just your role in the care of patients, but what other providers, staff, and administration need from you to strengthen the organization.

Beginning therapists in healthcare settings often have a mindset that several resources will already be in place. This is not only an unlikely scenario but hinders one's ability to pursue new collaborations in the clinical setting. New therapists should be proactive in their talks with other providers and budget their time to form these partnerships in their respective settings. Beginning therapists often learn about their system and organization through listening, observing, and shadowing providers at their site. Even emailing or "tasking" a provider through an electronic health record (EHR) will help other members know the presence of the provider and their willingness to collaborate. Despite using an EHR for continual communication, new therapists need to recognize the barriers that technology creates in establishing relationships with colleagues and providers.

Initiating Conversations with Providers

When mental health professionals think of the workflow of a doctor, they often assume several barriers that will get in the way of communication. Issues of time availability, scheduling longer psychotherapy appointments, consideration of mental health in the patient's care, and lack of knowledge about the therapist's role are often common challenges. A vital part of the early establishment of relationships is

effective and intentional communication with medical providers. Without letting them know your role and information about certain patients, one becomes invisible at times in a clinic. For instance, a new BHP might be unfamiliar with the medical complications and treatment approaches of asthma. After receiving a "warm handoff" from the physician to see the patient and his mother for behavioral health issues, the family asks several medically oriented questions to the BHP. After the consultation, the BHP and physician can arrange to either have a brief hallway consultation about the information shared, or the therapist can "task" the physician through electronic medical records.

Again, much of these initial conversations should be the BHP looking to offer help for patients and establish referral networks with these providers. It often takes several weeks or months for these initial collaborative efforts to pay off. It is easy for new BHPs to feel like they are forgotten or unwanted and begin to doubt themselves, but often persistence and patience will pay off in respectful and effective collaborations in the long run. As someone who learned to integrate into three different healthcare settings during my (Max's) graduate training, making these collaborations early and often with healthcare providers takes time. That is why supervision of new interns should place a greater emphasis on bumpability (Gunn et al., 2015), where a BHP's effectiveness relies on the number of times bumping into colleagues for consultations and regular communication.

A personal experience around this situation happened during the first couple of months of my (Max's) doctoral program in an eating disorders clinic. While the clinic had extremely supportive mental health professionals, nutritionists, and dieticians, I was often reluctant to initiate conversations about follow-up issues of patients. It may have been from my initial lack of confidence as a new therapist, but also to manage my own anxieties about bothering other colleagues in higher roles than myself. My supervisor quickly reminded me, "You have a role in this clinic that is highly important and recognized by others. They need your collaboration in order to facilitate better care." This experience made me realize the added value of team-based care, where an established plan for patients and families must incorporate multiple disciplines of health.

Access to Care Resources

Another difference between traditional psychotherapy services and medical settings pertains to insurance and third-party payer issues. Many patients from disadvantaged backgrounds and low socioeconomic status may be greatly impacted from not getting appropriate medical services. These financial barriers can also impact patients from seeking mental health treatment in primary care and other established care settings. BHPs and other providers need to be creative in how they can construct team visits with patients so that multiple services can be covered with affordable billing options for patients.

BHPs often advocate for patients and families regarding access to care issues, reminding medical team members of contextual factors that may limit patient's options for treatment. Taking on this role of patient advocate can be a very valued role in a care team. Even if one did not receive much graduate school training around billing and access to services, they can still serve as a liaison for the patient and family to seek resources and referral option for their health conditions. In primary care, a BHP may provide a 10-minute consultation for a patient struggling to pay for pain medications and follow-up doctor's appointments. A free consultation might be a way to connect the patient with services outside of the clinic and establish a communication line where the therapist can periodically call the patient about their progress.

Pace of Appointments and Scheduling

Mental health professionals embrace autonomy and flexibility in seeing patients that fit their practice preferences. Those in more minimally collaborative positions, such as private practice or consulting roles, must fully manage all components of their job, including scheduling, billing, paperwork, and costs of their practice. In medicine, many of these job components are out of the hands of the BHP, where adjusting to a faster paced schedule and quantity of consultations becomes a norm rather than an exception. Same-day appointments may appear in one's electronic health records, with minimal lead time to learn background information about the patient or family. Periodic conversations with front desk staff are often needed to coordinate time for either routine patients or open blocks for meetings, consultations, or other team tasks.

New therapists must learn to adjust to unanticipated situations or consultations, which forces one to establish clear boundaries in how they allocate their time. Physicians may ask the BHP for a quick 10-minute conversation to help address a patient in crisis. The nurse practitioner may have to interrupt a meeting you are in and require assistance on a question about a patient. The transition from the 50-minute psychotherapy appointment to a briefer consultation model may be difficult for new clinicians to embrace. Both setting a clear agenda and being clear about the patient's/family's goals become of greater importance in these instances.

Understanding Power and Privilege in Medicine

The history of medicine has long seen an established hierarchy of administrative power. Power and motivation are often interlinked in medical education and early training, where physicians and other medical providers must "prove their worth" through intense training during medical school and residency. Specific roles are also

carried out by each rank in a medical setting, which can include medical directors, attending physicians, clinic coordinators, hospitalists, specialists, nurses, house staff, fellows, and administrative assistants.

New therapists must not only be aware of these power dynamics but also find ways to acclimate in this environment and offer a voice on the team. This can be a delicate balancing act that the BHP must follow, being aware that medical and administrative decisions need to be made by the appropriate people in the setting. This socialization process takes time and the BHP is encouraged to create gradual buy-in from other members. The new BHP must also realize that certain statements and directives towards them are not a sign of weakness, but rather of function of the strict time elements and efficiency in these settings.

Identifying Stigma in Patient Populations

What sets many medical settings apart from traditional psychotherapy is often the context for patients and families to seek behavioral health support. For a private practice therapist, a family will seek treatment for a particular provider for a specific psychiatric, emotional, or familial issue. The identified patient and family know the intent of the treatment and establishes goals to work on specific areas of their lives. In medicine, physicians will often "hand off" a referral in real time to a therapist, encouraging the patient to discuss a behavioral or medical issue on the spot. Patients may be unaware initially why they would see a behavioral health provider or what the end goal of that consultation would be. Terms that physicians and other medical providers should avoid when introducing the BHP would be terms that include the words "Psychologist," "Mental Health," or "Behavioral." Descriptions that include "Counselor," "Specialist," or "Team Member" are often better received from patients who may not understand the role that behavioral health serves in a medical setting.

The communication and language that is given to patients and families around the scope of a mental health provider is critical. Individuals from certain cultures, communities, and faith groups might have a negative connotation of using mental health services. A psychologist, social worker, licensed professional counselor, or marriage and family therapist might be seen to many as someone who is searching for any mental health diagnosis out there. It is very important that both the referring medical provider and behavioral health professional establish a level of trust and connection with the patient and/or family in this situation. BHPs play a key role in helping educate and mentor other providers around issues of stigma and negotiating the challenges of "selling" mental health to patients and families. The lexicon that physicians and other healthcare specialists use for behavioral health services in medicine is vital to help connect patients to appropriate services. BHPs will increasingly be in positions to coach other professionals on this topic.

The "Do's and Don'ts" of Working with a Care Team

Integrating into a new setting and care team can take time. The new therapist should consider several factors around the role they play in the team, while finding ways to get "buy-in" from physicians, administrators, providers, and staff. The following suggestions will help you develop your role integrate into the care team.

- *Do make yourself known to the staff early on and often*. Entering a new setting means establishing a new set of relationships with relatively unknown providers and staff. It is comfortable for a new trainee or intern to isolate themselves in their office or separate room. The concept of "shared space" becomes increasingly important not only for patient consultations, but to be also visible to other staff in your clinic. Forming 1:1 relationship with staff and providers will also give an opportunity to educate them on your clinical capacity and the conditions you can treat in practice.
- *Do make time to learn about the operations in your practice.* Outside of the clinical work that beginning therapists gear much of their focus towards, there are important operational and workflow aspects to consider. Understanding how the front desk operations connect to the rest of the clinic, practice, hospital, or setting is vital. The therapist should understand every space a patient may occupy in the practice setting. Knowing the room availability and workflow of the clinic or setting will also allow one to be more efficient in their role.
- *Do provide positive feedback to team members about their work.* Initial collaborations with healthcare providers often begin with getting "buy-in" about what you provide in that setting. Positive statements and validation to team members not only helps improve rapport, but also gets providers invested in your role of services to their patients and families. Even a simple statement such as, "Your collaboration with this patient around their depression treatment has really been beneficial," can go a long way towards building relationships with the care team.
- *Don't deny opportunities to learn more about medical terms, conditions, and knowledge from others.* Working in a medical environment enables a great deal of accessibility to other providers. Therapists have valuable opportunities to learn from physicians, nurses, medical assistants, and other skilled professionals about specific terms, conditions, labels, and treatments. It can be beneficial to ask colleagues to suggest information or resources to read on regarding certain medical topics. This shows motivation on the therapist's part and helps educate providers regarding the scope of conditions that BHPs can treat in practice.
- *Don't become isolated from the rest of the care team.* To assimilate in an integrated care type of practice, one must always be available to communicate with colleagues about patients. Some medical settings do not have the structure to foster hour-long psychotherapy appointments. Developing certain behavioral health skills (e.g., team visits, warm handoffs, huddle meetings, curbside consultations) can help BHPs encourage more team-based care and increase the presence of an integrated care culture in their setting. The more therapists become isolated into their own practice routine, the more distance they create from being a part of the care team.

- *Don't turn down working with patients with medical concerns.* A BHP in mental health is often equivalent to a primary care physician in the field of medicine. Both are the "jack of all trades" provider for their specific niche of practice. Referrals for patients to behavioral health should not be limited to just depression or anxiety. Physicians may want therapists to see a range of biomedical issues that need additional counseling help, such as diabetes, COPD, asthma, or smoking cessation. Therapists must be attuned to the psychosocial needs that may be underlying medical issues. A systems-based approach can help identify certain familial and social presenting issues. The BHP must continuously respond and attend to the needs of the family during any phase of the illness of the patient.
- *Don't think of yourself as "just a therapist."* To the new trainee, the role of a mental health therapist comes naturally; the therapist sees an individual, couple, or family for a presenting problem that needs psychotherapy treatment and interventions. In a medical setting, however, the BHP may have multiple hats that they must wear to attend to the immediate needs of patients and family members. One might serve as a health coach to provide psychoeducation tips for someone looking to quit smoking. In another instance, one might serve as a mediator or facilitator to handle a conflict that the patient had with a physician, nurse, or attending provider in the clinic. Therapists must be aware that they can get pulled into a variety of scenarios that demand both instinctual and straightforward skills.

Case Vignette

Maria is a third-year doctoral student who is starting a year-long internship in a diabetes clinic affiliated with her university. For three years prior to graduate school she worked in a mental health clinic that served patients and families in the Latino population. Maria was very comfortable in this setting, where clients not only appreciated a Spanish-speaking therapist, but also her strong therapeutic skills in traditional psychotherapy appointments. She had her own office and could easily refer patients to a medical clinic down the street that offered psychiatric and lab services. Transitioning into a new clinic with relatively unknown providers was now a little intimidating for Maria. Having to establish new relationships and learning a new system was something she knew would take some time.

When Maria was available to receive handoffs of patients from the two endocrinologists, she came across several families who were somewhat skeptical about mental health services. She was having trouble with patients following up for routine behavioral health consultations. Unlike her previous experience in which families with complex cultural and relational issues embraced her style of therapy, a couple referred for potential conflict around health management at this site was very skeptical of the word "therapist" or "counselor." The patient stated to Maria, "Not only does my doctor get mad at me around my diabetes, but now you both think I'm crazy? I didn't sign up for this." Maria did not anticipate the level of resistance from the patient, especially since they shared cultural backgrounds.

Adding to the complexity of Maria's transition into this clinic was her own family's history of diabetes. Maria had an interest of working with this population, given that her uncle recently passed away from complications of diabetic ketoacidosis (DKA) after a hospital admission. She remembers how her uncle struggled to regularly maintain his insulin injections and the frustrations his providers had over this. When one of the endocrinologists referred a couple with a patient with DKA, Maria jumped on the opportunity. The wife was frustrated with her husband's noncompliance with his insulin, having been hospitalized twice in the past year over dangerously high blood sugars. Maria was convinced that she could help solve some of the issues for the family. She developed a comprehensive treatment plan, put together several resources, and checked in with the wife three times over the next 2 weeks on the phone. Although Maria felt like she was making a big difference in their lives, it turned out that her several recommendations overwhelmed and frustrated the couple even more.

When the couple arrived at their next appointment with their doctor, the wife expressed some frustrations with Maria being "too intense in her recommendations and calling us to check in." When Maria was excited for the physician to make another same-day referral for behavioral health, she noticed that the couple left right after the doctor's appointment, and they were not scheduled on her list of patients. The physician spoke to Maria about the wife's hesitation to seek behavioral health services and made some recommendations to Maria about easing into the treatment with patients who have had DKA. When Maria brought up this case with her supervisor, she was noticeably upset. As they processed the details more, Maria quickly realized that she was trying to "save the couple," as a response to not being able to save her uncle who recently died of DKA. It was a hard but impactful learning opportunity for Maria, where she began to realize how her family of origin and personal issues around diabetes had a strong connection to her style of patient care with this couple.

The case of Maria's patient experience is a good illustration of several "self-of-the-therapist" areas that can impact a new professional in this type of setting. Maria was impacted by not only a cultural issue of the perspectives of behavioral health in practice, but a personal one that may have impacted some of her work with diabetes patients. Students such as Maria need supportive yet direct supervision to help process these feelings and find ways to work through challenges in training. Supervisors also can help by shadowing the provider-in-training on-site, where other team members will be encouraged to offer support to this student. For those in the early stages of their careers, finding peer mentoring or process groups will help normalize these challenges. We also advise that new professionals attend local and national conferences that address the financial, operational, collaborative care, and policy aspects of medical settings. The remaining chapters will help you get an overall sense of the different areas of the "self" that are important to keep in mind in these practice settings.

This is an exciting and opportune time for BHPs to be on the forefront of medicine and integrated care services. With the emergence of new roles, responsibilities, and treatment approaches comes a new territory that mental health professionals are

occupying across disciplines and departments in healthcare. For early career professionals who are learning the basics of the medical world, the remaining chapters will introduce practice and personal areas that often challenge the morals, values, and confidence of BHPs.

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Personal Illness and Family of Origin

Jackie Williams-Reade and Max Zubatsky

As behavioral health professionals (BHPs) begin their work in the medical field, they face many new experiences for which they typically lack preparation and experience. They will be present for a patient as they receive a heart-breaking diagnosis; witness complex conflicts between patient, family, and/or medical team members; or see first-hand the impact of health disparities on patients and families. As discussed in chapter "Navigating the Culture and Context of Medicine", these tasks differ from previous experiences in traditional therapy and are not typically covered in the education content in school. These experiences can challenge us personally and it is important to attend to the unique self-of-therapist work required when we are working in the medical care system. In this chapter, we address how clinicians can engage in a personal exploration of individual and family aspects of illness and offer suggestions for how to integrate these personal experiences with the professional role.

Working in the medical field can elicit strong emotional responses to a variety of stressors unique to medical care. Many BHPs come to working in the medical setting influenced by personal stories of illness and are "wounded healers" (Nouwen, 1979), using personal experiences of suffering to fuel empathy and connection to the suffering in the lives of others. Empathy – alongside the quality of the relationships that therapists have with patients and families – is one of the most powerful predictors of positive care outcomes (Elliott, Bohart, Watson, & Greenberg, 2011; Norcross & Barnett, 2008; Norcross, Beutler, & Levant, 2005; Wampold, 2001).

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Empathy and other personal factors are referred to as "self-of-therapist." Being mindful to our self-of-therapist includes the ability to reflect on and be aware of how one's values, personality, beliefs, behaviors, and biases may influence clinical practice (Bean, Davis, & Davey, 2014).

Murray Bowen, a psychiatrist and one of the original pioneers of family therapy, believed that one's personal work with their family was the most important predictor of being able to conduct successful therapy (Bowen, 1978, Kerr & Bowen, 1988). Thus, it is essential for clinicians to understand how their individual, family, and sociocultural experiences of health and illness play a role in their ability to create positive and effective therapeutic relationships with patients and family members. Yet, despite the crucial role that therapists play in successful therapy outcomes (Blow, Sprenkle, & Davis, 2007), BHPs rarely receive training in how to address their interpersonal and intrapersonal processes as they relate to working in the medical settings. Behavioral health providers (BHPs) need to explore their family's intergenerational processes regarding illness that need to be resolved so they do not occlude therapeutic outcomes (Aponte et al., 2009). Understanding how these experiences may influence current reactions can help transform them into powerful tools to help facilitate patient change (Rolland, 2018).

For the behavioral health professional (BHP), this self-of-therapist work should extend to a focus on how illness in one's personal life, family of origin, and in the greater social context may influence their clinical work in both positive and negative ways. As a clinician and trainer, I (Jackie) am committed to addressing self-of-therapist dynamics for myself and my trainees. I work to acknowledge and address how my own lens is influenced by my experiences with personal and family illness and social locations. For instance, sometimes I am teaching a course while having recently experienced a positive medical encounter; while other times I have recently experienced a negative one. I may have recently felt my pain was minimized due to being female or witnessed how my privilege of being white allowed me the benefit of having my concern being taken seriously. In class, we may be reviewing an illness that one of my loved ones has lived with or died from. These personal realities influence my ability to be present to others – whether it's a patient or a student – and can also provide important insights into my teaching. As a clinician and trainer, I have a position of power that I also need to be accountable to in that I can pass on unexamined thoughts and feelings regarding the medical world to my patients and students. Using my experiences is an important part of my teaching; however, if my experiences lead me to emphasize the areas of deficit in medicine or overlook the experiences of those that are different from mine, these ideas can be transmitted to students, supervisees, and patients. Thus, it is a continual and careful dance for me to be mindful of how my experiences may be influencing my practice in both positive and negative ways.

Individual and Family Influences

Illness touches all families and, thus, clinicians working in medical settings typically have personally experienced an illness. These illness experiences often inspire BHPs to help others with the same illness or a similar illness experience. Many feel a desire to give back and this mission provides fuel and focus for their clinical work. However, it can also create blind spots or places where they may avoid challenging patients or family members.

Understanding the influence of individual and family illness narratives (Kleinman, 1988) is an important part of the self-of-therapist development when working in the medical culture. Clinicians often have increased empathy and insights for patients and families yet can also struggle with key clinical skills. They may over-empathize and not challenge patients and families, be blind to dynamics that are similar to their own, or harbor resentments towards the medical system. Being aware of one's experience and greatest strengths and struggles in our clinical work and attuning to these experiences can ultimately help us adjust our perspective which can result in more powerful clinical abilities. The following case examples provide insight into how individual, family, and socio-cultural influences can surface for BHPs and the effects they can have both personally and professionally. The following scenarios combine several stories and names and the identifying details have been changed to protect confidentiality.

Hermela

Hermela was an Ethiopian American female trainee who was diagnosed with fibromyalgia. She had years of experience of her pain and fatigue not being believed by friends, family, and the medical community. What emerged in her illness narrative was a strong emotional response to feeling dismissed and shamed by others for her challenges. Being from a culture in which respect for elders was tantamount, she found it difficult to speak up for her needs in her own family as well as with those in power such as her professors or supervisors at her clinical site. While she struggled, Hermela had done a lot of work to believe in her abilities and ask for the help she needed to succeed in classes.

In her clinical setting, being both a person of color and female gave her insight for patients who also experienced marginalization and discrimination and her work was culturally sensitive and successful. This confluence of social locations and experiences shaped her perspective and responses to patients, families, and colleagues in a beautiful and powerful way. She was often a fierce advocate for patients and created quick and strong relationships with colleagues at her site.

While Hermela's clinical skills were excellent, her performance at her site was greatly inhibited by the clash between her own sociocultural identity and the hierarchy of the medical setting. Hermela struggled in communicating with her colleagues and asking for referrals or support as she was influenced by her ethnicity, experiences, and gender to be hesitant in advocating for herself and sharing her needs. This was reinforced as when she did speak up she sometimes received the message that she was being too demanding or needy. In addition, Hermela would not share these concerns during supervision due to fear of not being believed, not wanting to be a problem, and feeling ashamed about her challenges.

Sociocultural identities of BHPs (which will be explored further in chapter "Making Sense of Socio-Cultural Context of Medicine and Identity Development") can play a significant role in successful and effective clinical work. When looking at Hermela, one can see how her personal experience with illness and her sociocultural identity both helped and hindered her work in the medical community. Sometimes a medical setting is not a good fit for a BHP and it can be due a variety of complex reasons such as personal experiences being triggered, being misunderstood or discriminated against in the medical setting, or a personality clash. Faced with this, it is a normal experience to find oneself feeling constrained and not able to show our best skills. In these instances, it is important to be able to acknowledge this for ourselves and find a way to bring out our best professional work which may mean additional supervision or a different clinical setting. For Hermela, this meant several conversations with the medical team and the supervisor to help work through the interpersonal challenges.

Arlene

Arlene was a female Caucasian student who was a dedicated learner and had insightful things to say about illness in class. After completing the illness genogram (see below) in class, she recounted her family illness story to fellow students and myself and primarily focused on her mother's diagnosis of Parkinson's being kept a secret for many years. She shared a significant level of frustration at her mother for her secrecy and felt it only caused her family and her mother additional suffering as they were cut off from social support leaving them unable to address the challenges head-on as a family. During her sharing, she also revealed that she was living with cognitive effects from a traumatic brain injury that she usually kept secret from even close friends (though she felt safe enough in our classroom to share.)

I was struck at the irony of her frustration with her mother for keeping her disease a secret while she was telling us her own diagnosis was being kept secret. I pointed out how her own secrecy towards illness sounded a lot like her mother's response. Her face portrayed a look of shock as she had not connected these patterns herself. This interaction, while uncomfortable to navigate in the classroom, brought an awakening to Arlene as it helped her more clearly see how responses to illness could be subconsciously transmitted through family interactions. This insight translated into her clinical work as she began to see and challenge the relational patterns

in her patients. Being able to speak about what she saw happening with herself and her family brought about more instances of change in her client population. These insights also benefitted Arlene as she took more pride in her clinical work and began to speak up more for herself in her own family and personal life as well. Unlocking her own emotional response in her family opened her up in powerful ways to both her patients and in her personal life.

As a professor, I have found that when students share personal reflections, unknown patterns, blind spots, or biases that they had not previously recognized in their personal lives often surface. When this awareness emerges, I work to connect their experiences to their clinical work. This may include bringing their biases to light, challenging discrepancies in their work, or asking questions about clinical areas they seem to have a blind spot. When we can see our own personal reactions to illness and work through them, it can be a powerful experience both personally and professionally. While these insights are often disconcerting and working through them can be uncomfortable, their payoff is significant.

Self-of-Therapist Development Recommendations

Conversations regarding individual and family illness experiences embedded in the larger social context are important in clinical development. From an individual perspective, our personal experiences, can influence how we make sense of illness. From a family perspective, we may have had a loved one living with an illness and we learned values and beliefs that sometimes operate subsconsciously. Contextually, social factors, values, and expectations play into our meaning-making and how we are perceived. These varied experiences form our beliefs and values about what patients and families may need when facing illness. If left unexamined, we may perpetuate personal, family, or societal values and expectations listening to versus what the patient and family needs and wants. Thus, taking opportunities to address one's illness experiences is an important part of integration into medical culture and there are several ways to do so.

A practical way to begin exploring the influence that individual, family, and sociocultural factors have had on you is by constructing a health and illness genogram (McDaniel, Doherty, & Hepworth, 2014). I (Jackie) have participated in this assignment in both my master's and doctoral programs, and it is a common assignment in many medical family therapy courses. All the individuals have their own unique identities and experiences with illness; thus, the areas in which they may need to work on will vary. However, areas of growth are often found in those unexamined beliefs and patterns for which we hold little awareness. The challenge for most clinicians is to recognize their lack of awareness and commit to the additional work required to facilitate growth. Conducting a health and illness genogram can increase this aspect of self-awareness and knowledge (Rohrbaugh, Rogers, & McGoldrick, 1992; Schilson, Braun, & Hudson, 1993).

Illness genograms enable us to investigate personal and family illness histories and seek knowledge in terms of how sociocultural messages about illness may be influencing personal beliefs and professional clinical work. This activity includes both a personal narrative paper as well as an oral presentation in class or during supervision. The genogram serves a dual purpose as it helps practitioners reflect on their own experiences and can also be used to learn how to use a genogram as an assessment tool with patients and family members. The material in this activity should be considered confidential and participants are encouraged to share what is comfortable for them. Accessing supportive resources, such as counseling services, are encouraged in the event the activity results in strong reactions.

In this activity, participants review their family history for intergenerational patterns surrounding health and illness. Practitioners are asked to create a three-generation (or more) genogram which includes:

- Nodal medical or health-related experiences
- The general health, illnesses, hospitalizations, disabilities, injuries, and cause of death of all family members
- Family patterns around grieving and managing illness
- Family beliefs and rituals surrounding death and illness
- Cultural practices, socioeconomic issues, gender/power issues, and attitudes toward wellness, health, illness, and medical care (include alternative medicine, traditional practices, intersection of spirituality/religion with health, etc.)

This exercise is helpful only to the degree one takes for exploration of these influences and identities seriously. For instance, simply creating the genogram with medical illnesses and dates of diagnosis or death is informative yet it may not provide significant personal insights. However, exploring the generational influences, family patterns, sociocultural concerns, and relational dynamics offers a rich source of material regarding the meanings of these influences and identities. This exercise can promote a variety of important characteristics for BHPs, including:

- Recognize and articulate one's own values regarding illness and family and how these may differ from those of the other individuals and groups
- Identify the impact of their personal experiences on their emotions, strengths, limitations, and behavior
- Recognize how one's experiences can create biases and understand how these can affect their judgment and behavior
- Practice in analyzing and acting on feedback to help with self-awareness

To facilitate a reflective experience while conducting the health and illness genogram, the questions in Table 1 can be used to elicit meanings and spur further insights from the genogram. The questions can be completed individually in a written narrative and/or they can be used in a supervisory or classroom context to verbally explore the illness narrative. In the completion of this activity, a variety of reactions such as unexpected insight or emotions may surface. In this way, the personal illness narrative is significant as it can bring about a strong emotional response and reveal reactions and vulnerabilities that need attention.

Table 1 Questions for health and illness genogram assignment

How do your family members react when someone has an illness?
How does illness influence the relationships between family members?
How does your family talk about illness or going to the doctor?
Who in your family is most/least involved in caring for family members with an illness? Do you see any patterns in this related to family roles or rules?
How does your family communicate and make decisions about illness and treatments?
How is the lack of adherence to medical treatment addressed by your family?
What kind of conflicts or disagreements occur in your family regarding illness or health? How are these resolved or why are they left unresolved?
How do you think your and your family's social locations (e.g. race, class, gender, sexual orientation, abilities, etc.) have influenced your and your families' experiences with illness and healthcare systems?
How have values from your family's culture, religious/spiritual beliefs, personal ethics, etc., informed your family's views of illness? How have you been influenced by these?
What has been your and your family's experience interacting with medical professionals/the medical system?
How does your family respond when a loved one has died?
Are there others who have influenced you or your family in regard to illness (e.g., friends, teachers, or community members). How did they influence you?
How do you make sense of your family's response to illness? What are the positive and negative aspects of your family's response?
What insights have you gained after considering your family's response to illness?
How do you think you and your family's experience with illness might influence your work with patients and relationships with other medical professionals?
How has the illness experience shaped your biases and beliefs about illness, medicine, and the medical community? Describe how you might work with these reactions.
If a BHP had been involved, what would/could they have done? How might things have been different today?
How has your family's experience influenced you in terms of your areas of strength and weakness when working with illness?

Paying attention to our individual, family, and sociocultural experiences related to working with patients with illnesses can help increase meaning and effectiveness in our clinical interactions. Engaging in an illness genogram and the associated reflection questions is a good first step; however, we need to continually engage in the practice of self-awareness and pay attention to our mental, emotional, and physical reactions. Understanding these personal aspects in medical settings is important as it is a fast-paced, challenging practice environment and a BHP could encounter a variety of events that could trigger a strong reaction on any given day. From working with an angry patient, a demanding schedule, or challenges to one's competency, a BHP can encounter a variety of stressors. In these moments, we often respond in self-protective ways which could lead to adverse outcomes, such as an angry outburst at a client's lack of progress or shutting down in a meeting after a

heated disagreement about patient care with a colleague. While these are normal responses to stress, it is important to be aware of them and work to respond in ways that can improve our overall care as well as take care of us personally and professionally (Gehart & McCollum, 2007).

Conclusion

Training BHPs to engage in self-of-therapist practices aids in achieving greater self-awareness into personal experiences as well as providing options to help manage the emotional reactions that may arise while working in the medical setting. The ability of clinicians to engage in self-reflection and take responsibility for the personal factors they may bring to the therapy process can help them improve therapeutic outcomes. Consequently, a central goal for those involved in behavioral health is to work on these self-of-therapist issues to be aware of their experiences and how they shape their responses in their professional work. As we engage in examining our personal reactions, we can become more mindful and conduct our work with our values leading the way.

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Coping with Patients' Death and Dying

Jackie Williams-Reade and Max Zubatsky

During their careers, behavioral health professionals (BHPs) will experience the death of a patient or work with patients who face the potential outcome of death due to their illnesses. BHPs trained in the areas of death and bereavement can provide valuable assistance to patients, family members, and fellow healthcare team members. However, engaging with these issues requires self-reflection in order to engage sensitively and appropriately. This chapter will explore issues of grief, loss, death, and bereavement imperative for BHPs to consider in order to increase sensitivity and competence in their work with a diverse range of patients and families.

When working in a medical setting, physicians are often responsible for breaking bad news to patients regarding a diagnosis, prognosis, and pronouncements that bring with them the possibility of death. In these scenarios, BHPs may be called upon to provide support during or after a visit when an uncertain or terminal diagnosis is given or be present for grieving family members after a patient has died (Edwards & Patterson, 2006). A key skill that BHPs must develop is the ability to remain present during these difficult experiences and conversations and learn to recognize and address their personal reactions around issues related to death and dying (Schaffer & Norlander, 2009; Watts, 2007; Worden, 2018). As BHPs increase their ability to be present during the suffering and intense emotions associated with death and dying, they can provide better care (Gamino & Ritter Jr, 2012).

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Participating in the support of patients and families facing grief and loss can provide personal and professional fulfillment, as accompanying others during these times of suffering can be very meaningful. Working with grief and loss may also pose a threat to our abilities to remain empathic and engaged in meaningful work due to the emotional toll it can have on us. For instance, if we have experienced our own losses or worry about potential future losses, facing others' pain in similar situations can remind us of our own. When these emotions surface, they can pull us back into our sorrow or cause us to put up a tough exterior to prevent our pain from seeping back in. However, as we face these difficult emotions within ourselves, we are able to better help our patients. The following sections will aid in this endeavor.

Personal Experience

My (Jackie) own experience with the death and dying of loved ones made a profound shift in my personal and professional life. During college my grandfather was diagnosed with pancreatic cancer and was given 4 months to live. I moved in with my grandparents and witnessed his daily decline and death as well as my family's emotional response to the suffering. It was a difficult time as I saw cracks in my family relationships and witnessed conflict over how to communicate with my grandfather and other family members. It was a painful process and stayed with me for many months. After several months, I decided to volunteer at a camp for children with cancer. This choice opened up a new career path as I then interned with the cancer camp agency, moved away from my hometown to work in the oncology unit at the large children's hospital there, and then was a part of a small team that founded a nonprofit organization for families with children with serious illness. I spent most of my days interacting with families in hospital waiting rooms, sitting with a parent or sibling while we waited for a treatment, visiting young children while they lay in their hospital beds, or attending many memorial services of children. Being a part of these family's lives was meaningful, yet deeply sorrowful.

This consistent exposure to uncertainty, loss, and trauma took its toll on my work and personal life. At work, I became lethargic, not able to focus, and questioned my role in helping these families. In my personal life, I began to discount my own and friends' suffering as I compared it to what these families were going through and found it insignificant. My spiritual life was shaken as I questioned the existence and power of God as I witnessed so much injustice and prayers go unanswered. My supervisor noticed changes in me such as spacing out during meetings and a decline in passion for my work, and encouraged me to seek therapy.

In therapy, I had a safe space to process how the death of children was shaking my foundational beliefs about myself, my life, and the world. My therapist helped me adapt to a new belief system and a way of thinking about my role in these families' lives. I began to take less responsibility for helping make their suffering go away and learn to sit in the discomfort of profound grief and loss. I had to face the existence of unfairness in life and learn to take my own and my friends' suffering seriously even if it felt insignificant in the face of my daily work.

While seeking therapy helped me greatly, it did not protect me completely from moments of sadness or difficulty when working so closely to such deep suffering. I continually had to work to take care of myself so that I didn't overly identify with others' suffering or allow the pain to take away the joy and meaning in my own life. Having learned from this experience, my hope is that the rest of the chapter will help highlight and formulate ways to address the challenges BHPs will often face when working with the potential death and dying of patients.

BHPs, Self-of-the-Therapist, and Death and Dying

Our response to sensitive issues around death and dying is unique for each individual. One's personal response may be based on a number of factors, including personality characteristics, previous experiences, or cultural issues. The type of relationship with the patient and/or family members as well as the circumstances surrounding the death may also play a role in how it impacts us. For example, if a patient dies from breast cancer due to genetic factors, sadness and sympathy may follow in a relatively straightforward manner. However, if a patient dies from liver cancer due to drinking too much, responses of sadness and sympathy may be complicated by anger and sense of patient culpability.

Experiencing the death of a patient can be an isolating experience as typically a BHP may not be able to turn to friends for support due to confidentiality or, if sharing general details, may find that friends do not understand the depth of grieving for a patient. In addition, fellow colleagues who also experience the death of patients may not be open to these conversations. The medical culture tends to be reserved in terms of emotional expression and may not have resources to support employees in these challenges. Because of these factors, BHPs may question the appropriateness of their feelings and not share openly with supervisors or colleagues which can leave them with little support. In addition, they may also be called upon to provide grief counseling to other patients, family members, or colleagues while going through their own grief as well. The following case represents an example of a BHP intern encountering the death of a patient for the first time.

Case Example

Kendall, a female African-American student, began her internship in the trauma unit at a large medical center. She worked with many patients who had experienced traumatic injuries or illness complications, and often who were facing potential death. Upon the death of her first patient, Kendall was shocked and surprised at the impact that it had on her personally. She felt a strong connection to the patient, who was of a similar age to her parents (one of which was also in poor health). The day the patient died, she had not been able to see him due to a busy schedule. When she came to check on him the next day, a different patient was in the bed. Having not

been able to say goodbye, Kendall felt she had failed the patient and family. She tried to put her emotions aside and focus on the tasks of caring for other patients, but over the next few weeks found herself feeling increasingly detached from patients, falling behind on charting, and experiencing her own feelings of depression. In supervision, she shared that she did not feel that she needed to discuss the death in supervision or engage in grieving activities, such as attending a funeral or taking time off work. Several months later, Kendall was able to reflect on her personal struggles and shared how she felt ashamed that she was having such a strong emotional reaction about a patient's death at the time. She felt it suggested that she was experiencing countertransference or had become too emotionally invested in her patient. This interpretation of her emotions led her to not share with those who could best support her, like her supervisor, or engage in appropriate grieving activities.

As this case illustrates, BHPs can be profoundly affected by the death of a patient, but uncertain as to how to cope with the experience. Had Kendall been trained to recognize her limitations and strong emotions as normal when caring for a patient who had died, she likely would have felt more comfortable discussing her reactions in supervision. Kendall's response also suggests that her work environment may not have provided resources for her when the death of a patient occurred. By understanding these emotions as being a part of professional experience and not simply her own personal feelings, Kendall may have also been more willing to engage in grieving activities that could have been beneficial to her both professionally and personally. Issues of countertransference, lack of time, diversity in grieving, and cultural and spiritual values and meanings are all aspects of working with death and dying and are all areas to consider when working with patients and families facing grief and loss.

Countertransference

The relationships that BHPs develop with patients are unique and can result in strong and complicated feelings if a patient dies. Strong feelings about the patients we work with can be stressful and require additional emotion management (Mann, 2004; Mann & Cowburn, 2005). While personal connections and compassion are often core values and sources of meaning for a BHP, these can also heighten the emotional responses that result from a patient's death. It can be difficult for BHPs to acknowledge these feelings as they may be perceived as countertransference and feel inappropriate in a professional context. Countertransference is especially salient when working with those anticipating or coping with death because we are working with patients and families during a very vulnerable experience: the end of life (Katz, 2006).

A therapist's personal beliefs, anxieties, and fears about death can easily leak into the therapeutic relationship. For instance, part of Kendall's emotional response may be connected to the similar age of the patient to her own parents,

which would complicate her grieving process. This unaddressed countertransference could cause a therapist to avoid bringing up pertinent issues to the patient and family as they feel helpless or overwhelmed in the face of death-related concerns. Therapists are also at risk of taking on too much responsibility for the patient and family experience. BHPs may believe that they should be able to alleviate the suffering entirely to be successful. They may have their own insecurities such as not wanting to make a mistake or fail the patient and family. In these situations, it is important to remember that the goal is not to take away the pain, but rather to be present to the pain and help support meaning-making in the experience. Developing awareness of strong reactions and their influences is a key component of professional practice in grief, loss, and bereavement (ADEC, 2010). Recognizing these feelings in oneself can help BHPs make sense of their strong emotional reaction and facilitate working through them in order to provide an appropriate therapeutic response.

Time

Another clinical challenge when working with a patient who is dying is the factor of time. Time can feel extremely shortened when the time remaining for a patient's life is brief. Or time can feel like it's dragging on as we are aware that death will occur but unsure as to when. Issues of time can intensify the therapeutic process and relationship as it requires the BHP to determine priorities quickly and accept a more limited scope of outcomes. The patient's mental abilities or level of energy may also be limited, which can restrict the ability to make big changes. Further, a dying patient often has a variety of professionals involved and the increased coordination needs can also limit the time available.

The time limits of therapy when working with death and bereavement are a reality. For the case example above, Kendall's experience of not being able to see the patient before death can be a common experience due to the constraint of time in terms of a life-threatening illness. By normalizing that time is a significant factor in clinical care around these issues, Kendall may have been able to better understand this constraint as a common factor rather than blame herself for not being able to be present.

Workplace Culture

Kendall's experience in the case example also brings up questions about the work environment she is in and the kinds of resources it provides for employee grief support. Without organizational resources, one can begin to question one's effectiveness and become disillusioned with one's role, institution, or the world at large (de Jonge, Le Blanc, Peeters, & Noordam, 2008; Lee, Lovell, &

Brothridge, 2010; Yang & Chang, 2008). Work environments differ in the amount and types of resources they offer regarding the death of patients. Some may have no support or rely on an informal structure in which employees take care of one another, check-in about how they are doing, and overall provide an understanding and supportive environment to grieve and get support (Lima, Cavaliere, & Porensky, 2014). Other environments may have formal supports in place such as peer group debriefings, referrals to psychosocial support, or workplace rituals to acknowledge and honor patients' deaths (Stone, 2018). However, it is important to note that even in an environment that does provide support to staff for dealing with death, sometimes interns are not included in these activities. This could be due to the intern's limited availability on site or because they may be overlooked since they are not a formal staff member.

Another complication in workplace support is that BHPs are often seen as the ones who provide the emotional and/or supportive work. Since they are seen as the experts on issues of emotions and psychosocial experiences, they may be considered the main support for others but their own needs for support may be not be addressed. For the BHP, receiving professional support regarding issues of death and dying may require actively seeking it out. Options can include talking to a supportive colleague or supervisor, finding external support through professional development trainings, or talking with friends who can accept and support this kind of professional grief.

Diversity in Death and Dying

While illness and death are universal, the human experiences, meanings, and preferences we hold around illness and dying are very diverse and a cultural experience (Ho, Chan, Ma, & Field, 2013). A significant way in which people cope with death and dying is through finding meaning. This may include making sense of the death, finding benefit, and/or reorganizing one's identity (Neimeyer, Baldwin, & Gillies, 2006). Death and dying bring up a myriad of ideas about the meaning of life, how life can be unfair, questioning of deeply help spiritual values and beliefs, and more (Neimeyer, 2002). For many, this meaning-making is often directly connected to religious or spiritual beliefs (Sulmasy, 2006). To provide appropriate empathic response to those experiencing death and dying, BHPs must be able to empathize with others and recognize similarities and differences between their own cultural values and meanings and those of their patients.

Cultural dimensions such as ethnicity, gender, social class, family beliefs, religion, worldview, and other influences contribute to patient and family members' behaviors, beliefs, and values in relation to death and bereavement (Galanti, 2014). Western society often has a death-denying aspect such that it is common to fight death or hold out hope for a cure or healing until the very end. For Eastern cultures, death is often more accepted as a part of life and is not as much of an "end" as it is a transition or beginning of a new stage of life. Culture can influence the emotional

expression around grief as some will grieve outwardly for long periods of time and others will respect a more restrained approach. While the United States values informing patients about their illness and if it becomes life-threatening (Lowey, Norton, Quinn, & Quill, 2013), other cultures may prefer that patients not be included in these conversations as it can be believed to only add suffering or perhaps hasten death. Keeping cultural context in mind with an attunement to how an individual may or may not align with cultural norms or generalizations is an important part of a BHPs practice.

Individuals from different cultures have different preferences regarding end-of-life choices, such as the location they would prefer to die in, drug treatments, and utilization of assisted breathing devices Rodriguez et al. (2007). These differences regarding preferences for care can be very difficult for the healthcare team, as some of these decisions may seem unethical from their own cultural standpoint. For instance, Jehovah's Witnesses do not typically approve of blood transfusions as they consider this an act that would be disobedient and disrespectful of God (Chand, Subramanya, & Rao, 2014). This belief and action can cause an ethical dilemma for providers who may be informed by Western medicine that values patient autonomy in decision-making and pursuing all possible treatments.

Working with patients and family members around issues of death and dying can raise a wide spectrum of meaning, beliefs, and values. This diversity in meaning can cause conflict between patients, families, and healthcare team members. In these instances of conflict, BHPs are often called on to advocate for their patients to other medical professionals and can share insights into the patient and family experience that influence their decision-making. Helping to bridge these relationships is a task of the BHP and is often undertaken while the BHP themselves experience value conflicts. Again showing the importance to be able to balance one's own reactions with those of others.

Self-Care When Working with Death and Dying

For BHPs working with death and dying, exposure to the suffering of others requires attention to self-care practice (Mendenhall & Trudeau-Hern, 2013). BHPs need to both help patients and family members cope with grief and loss, while also caring for themselves (Edwards & Patterson, 2006; Kumar, D'souza, & Sisodia, 2013). Recognizing and processing feelings of grief can be beneficial to both BHPs, patients, and families (Negash & Sahin, 2011; Sanchez-Reilly et al., 2013; Worden, 2018).

Self-care is a biopsychosocial–spiritual practice. Biologically, one must get adequate nutrition, exercise, and rest. Psychologically, attending to one's thoughts and emotions which includes gaining education and support in grief and loss is important. Socially, one needs to engage in close relationships and establish boundaries. Spiritually, practicing mindfulness or spending time engaging in important spiritual practices such as spending time in nature is important.

While the death of a patient is different from the death of a loved one, there are similarities that can be helpful to explore. The *Four Tasks of Grieving* were suggested by Worden (2018) as important stages that must be worked through when facing the death of a loved one. The model also provides a roadmap for professional grieving. Table 1 provides an outline of these four tasks adapted to a BHP. It is important to note that these tasks do not happen in order. They may overlap and need to be revisited over time.

Engaging in personal and professional self-care not only can protect against burnout, compassion fatigue, and moral distress, but can also promote one's engagement, compassion, and resilience. When one attends to their personal and professional self-care, increased job satisfaction and purpose can improve. Providing care for patients and families during the dying process can be a rewarding practice and can help cultivate a sense of meaning and purpose (Sinclair, 2011).

Table 1 Tasks around coping with death and dying

Task #1: *Accept the reality of the loss*	This task includes coming to terms with death. It is common to experience shock, denial, or disbelief after the death of a patient and it can feel surreal that they are no longer alive. Accepting the reality of the loss is working through this process and being able to acknowledge that the death has happened. It may be helpful to engage in grieving rituals such as attending the memorial service or sending a note to the family to help bring a sense of acceptance
Task #2: *Work through the pain and grief*	This task refers to the emotional work of grieving; this includes feelings of sadness, anger, confusion, anxiety, etc. This work is taxing emotionally but can also cause physical symptoms such as exhaustion, loss of appetite, difficulty with decisions, lack of mental focus, etc. It is also important to attend to self-care activities such as trying to get adequate sleep, nutrition, social activities, and exercise. You may need to take time away from work to grieve – sometimes this can mean taking a day off for an especially difficult experience or making time in your day-to-day life to grieve
Task #3: *Adjust to a new environment*	This task includes adjusting to a new awareness that the patient has died or perhaps the knowledge that patients die. This new awareness can make one feel as if their entire workplace or job has changed and one must make changes in order to adjust. This adjustment to a new environment can happen over an extended time period and can require personal and professional adjustments. Personal adjustments can be regarding your own sense of purpose or beliefs, while professional adjustments may include learning new skills or establishing additional support resources. This can include coming to a new awareness of your role as a grief counselor and a professional who experiences the death of patients. It may include additional personal self-care or a realignment of your feelings about your job
Task #4: *Find enduring connection with the deceased while moving forward with life*	This task includes finding connection in our emotional lives with the person who has died. For the BHP, this can mean allowing memories of patients or family members to peacefully exist within our minds or finding new activities that keep us connected to the meaning in our jobs. This task can be ongoing for the BHP as one copes with continued suffering and loss and connections to those people and their experiences may vary case by case. Consulting with team members, a therapist, or members of a spiritual community can be a helpful way to work through how this meaningful connection might appropriately look for each individual

Self-of-Therapist Activities

Training programs often fail to adequately prepare clinicians to treat those grappling with their patients' death or those affected by the death of a loved one. To help address this gap in trainees' experience, some potential teaching or supervision activities are provided below. Through these activities, clinicians can develop an awareness of personal beliefs and experiences and how these may influence their response and coping with the death of patients. See Williams-Reade and Trudeau (2018) for additional self-of-therapist activities related to death and dying.

Personal Reflection

One activity to promote personal insight and professional growth is personal reflection that engages one in further understanding and bringing a critical consciousness to their personal family experiences regarding death and dying. Through the following reflective questions, a BHP can trace how one's family responds to the issues of death and dying. The reflective questions to ask include:

(a) How has my family discussed and coped with death and loss?
(b) What beliefs and values do my family members hold regarding death and grief?
(c) As I look at my family experience with death and grief, what patterns of coping do I see?
(d) Considering my family's experiences, which grief, loss, and death experiences might be difficult for me?
(e) How can insights from looking at my family inform my clinical work?
(f) What do I know about how other cultures think about grief, loss, and death?
(g) What are my personal beliefs and values regarding death? What do I believe happens when we die? How do I think people should and should not grieve?
(h) Where do I get my ideas and values about death and dying from? How might the dimensions of my personal context and culture such as my age, ethnicity, social class, etc. influence my beliefs and responses?

Our beliefs and reactions to issues of grief and loss are often formed in our family of origin. Exploring and working through one's answers to these kinds of questions can help us better understand where our thoughts and feelings about death and dying come from. This awareness can help us better prepare to encounter death and dying in our clinical work as well as engage in self-care around these issues.

Advanced Directives Activity

Another activity that can be useful in helping us have discussions with patients and family members about death and dying is working through our own experience around this kind of conversation. One way to simulate this would be to fill out an advance directive document. There are several free or sample documents online that can be used. After completing an advance directive, respond to the following questions:

- What thoughts and feelings come up for you when thinking about your own mortality and future death?
- What experiences have you had regarding death, dying, and bereavement? How might those experiences influence your clinical work?
- What unfinished business would you want to address if you knew you were going to die soon?
- What are memorial/funeral service elements that you find most meaningful and would want included in your own?
- What are your feelings regarding organ donation?
- What are your views on assisted suicide and right-to-die legislation?

Thinking of one's own mortality is a challenge that often one doesn't need to face until a crisis occurs. For the BHP, it is important to understand their own reactions to this kind of conversation, and one way to do this is to engage in thinking about our own mortality. While this may sound dismal to some, it can be an important part of our professional work in that it can help us work through some of our emotional responses that may negatively influence therapeutic interventions with patients and family members. By engaging in these conversations, we come to more clearly see our sometimes latent values and beliefs and address them so as to provide a more empathic and therapeutic conversation with others.

Conclusion

For BHPs in medical settings, working with patients and families who are facing death or bereavement is a necessary area of therapeutic care. BHPs need to receive training to facilitate an increased understanding of the impact this has on their personal and professional experience. BHPs can be a key player in helping medical teams create team processes, facilitate team meetings, or help create learning opportunities around professional self-care in response to working with death and dying. Clinicians should be up to date on the literature on death and dying as well as their own experiences and plans for self-care strategies for when they encounter deep suffering in their work. By preparing and caring for ourselves in this way, we can continue to be present for patients, families, and colleagues in our work lives and for ourselves and our loved ones in our personal lives.

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Making Sense of Sociocultural Context of Medicine and Identity Development

Jackie Williams-Reade, Brittany Huelett, and Max Zubatsky

Medical settings represent unique cultural contexts wherein a variety of patients, disciplines, and staff are joined together. This chapter explores the sociocultural norms and values that can be present in such contexts, and how they can be challenging for behavioral health professionals (BHPs). Emphases on BHPs whose identity is of a historically marginalized group in the United States are also explored.

The Sociocultural Context of Medicine

The current U.S. healthcare system includes the constant mixing of societal values, patients' and families' unique cultural contexts, and the various perspectives of multiple disciplines all working together. These systems coexist and influence issues such as communication, beliefs about illness and health, and the conceptualization of treatment, goals, and outcomes for care. For the BHP, being aware of these differences and knowing how to navigate them are essential to successful clinical practice.

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Traditionally, training in this domain focuses on how to provide services to a spectrum of patients attending to unique needs related to class, race, gender identity, age, education, language competency, culture, illness beliefs, and more (Bean, Davis, & Davey, 2014; Caldwell & Galiardi, 2014). Addressing these issues consistently requires commitment from the individual clinician as well as the entire medical team and organization. An essential part of a BHP's work includes understanding these unique needs and adapting our practices to meet them. What is often not discussed is the social identity of the BHP and how the match between their own and the prominent characteristics valued in medical culture may influence their role and overall professional development.

BHP Professional Identity Development

A clinician's professional identity is developed through an understanding of their professional self within the field in which one is attempting to orient themselves (Brott & Myers, 1999). When BHPs do not match the "norm" of the medical culture, it can create challenges and discomfort regarding professional identity development that often go unaddressed in training or supervision. As clinicians navigate the environment of integrated care settings, an important aspect to consider is the power structure that exists within the healthcare environment (Janss, Rispens, Segers, & Jehn, 2012). Prior to the integrated care movement, physicians and therapists were viewed as competitors as healthcare relates to the perspective of understanding and provision of care (McDaniel, Doherty, & Hepworth, 2014). There has been a continued shift within the field in which healthcare providers are learning to share and conceptualize the perspectives and viewpoints of their behavioral oriented colleagues (Hodgson, Lamson, Mendenhall, & Crane, 2014; Interprofessional Education Collaborative Expert Panel, 2011). Despite this shift, BHPs are still tasked with acculturating to the healthcare context.

The U.S. medical system is a framework in which physicians typically hold a primary position within the workplace hierarchy. As BHPs work and attune to this hierarchical structure, they make connections to how they see, understand, and make sense of their professional identity. The hierarchy in medicine typically affords the physician a significant amount of power as leaders of the medical team. This privileged status may leave BHPs and other team members hesitant to question the provider or to voice their own unique concerns, conceptualizations, and/or perspective on patient cases. Due to differences in medical training, team members often speak differently about cases. Medical professionals may speak in an objective, linear manner in terms of treatment conceptualizations. BHPs, on the other hand, may conceptualize the patterns of interaction of multiple systems as leading to symptomology. These differences in conceptualization bring recognition to the inherent differences of professional position amongst the disciplines. The ways in which the BHP understands these differences and how their contributions are

accepted (or not), incorporated, and utilized in the medical setting will influence how they make sense of their developing professional identity.

Medical Culture and BHP Professional Identity

Each workplace culture has certain norms and expectations for how emotions should be handled (Hochschild, 1983). An aspect of professional identity development for the BHP is the practice of emotionally demanding tasks inherent in working with patients and families in a medical setting. Medical culture has been long studied in terms of emotional experiences and expression at work (McQueen, 2004; Parsons, 1951). Being a professional in a medical context includes working with patients who are ill, which can elicit strong emotional responses from both patients and family members as well as medical team members.

This emotional work on the job can be understood through emotion management theory (Hochschild 1979, 1983). Emotion management theory suggests that individuals engage in surface and deep acting as forms of emotional labor. Surface acting involves adapting your expression of emotion, such as laughing when you are sad, in order to present a certain emotion to others. Deep acting includes the work done to try to make your internal feelings match the expected emotional norm of a situation, such as trying to make yourself feel happy when you are sad. This acting is shaped by social context as we are informed by culture as to how we should respond emotionally and we typically will act in order to adhere to this standard.

In healthcare settings, emotional labor is shaped by the culture of the healthcare system as one that is embedded in economic, political, and social contexts. This emotional management includes maintaining one's professional image; emotions in reaction to illness; reactions to challenging patient/family encounters; and reactions to the medical system, colleagues, and culture at large. Not being able to manage these emotions may have serious consequences both personally (e.g., depression, interpersonal conflict) and professionally (e.g., making errors, inability to accomplish one's responsibilities, or difficulty working as a team). For example, a lead on the medical team may have an emotional response to a patient's complications with an illness, which is seen by various team members as an inability to maintain composure in a stressful work environment. Our inability to handle our emotional responses in accordance with the cultural norms can tarnish our professional image that may create doubts regarding our role and ability as a leader.

Social Identities and BHP Professional Identity

Beyond the hierarchy of the medical system, another area that has the potential to impact the professional identity of clinicians is the intersectionality of one's societal standing as it relates to race, gender, sexual orientation, and cultural background.

While each context has its own rules for emotion management, each individual is also held to different emotion norms and, thus, the amount of emotional labor we must perform in our jobs varies (Lovell, Lee, & Brotheridge, 2009). A clinician who is a member of a minoritized group often engages in additional emotional management compared to those who are more privileged or closely align with the cultural values and norms. This additional emotional management is often found in managing how they are being perceived by others.

Social identity theory (Tajfel & Turner, 1986; Ten Hoeve, Jansen, & Roodbol, 2014) suggests that the self-concept of an individual or a group is derived from the perceived image of the group by society. Thus, the way individuals view and understand themselves may be influenced by the way society perceives, understands, and accepts an individual's social location. For the BHP, the ways in which they are perceived, understood, and accepted by patients and other medical team members may have an impact on the development of their professional identity, the way they feel they should present themselves in the medical setting, and how they perform their role.

Gender and Race and the BHP Professional Identity

Gender and race are two primary identities that we will explore in how they may challenge a BHP's professional identity development in medical settings. The following are examples of how these different identities may be perceived by BHPs, and how a BHP's identity can be influenced by these social identities. The discussion of these issues is not to suggest that all medical contexts and settings value the same norms or treat BHPs of minoritized groups the same way. The authors acknowledge that many BHPs of various social identities are in supportive medical contexts that are addressing these challenges head-on and creating a new kind of medical culture. These ideas are meant to engage in a conversation that is often unaddressed in order to help prepare BHPs and trainers/supervisors to speak candidly about these issues.

In regard to gender, the medical field has been criticized as a heteronormative setting in which participants – including patients and medical team members – can experience stigmatization (Eliason, Dibble, & Robertson, 2011; Zimmerman & Hill, 2006). For those who are of the stigmatized group, they may be hindered in being valued or obtaining roles of leadership in professional environments due to gendered norms and expectations (Henderson, Simon, & Henicheck, 2018). Psychotherapy is often perceived as a more female profession due to its emphasis on addressing emotions, and most mental health professionals are women (Erickson & Ritter, 2001; Simon & Nath, 2004). For those who identify as male in a BHP position, they may have to navigate ideas regarding their masculinity in response to being in a profession that primarily consists of women and works with emotions (U.S. Department of Health and Human Services, 2017). For those who identify as female, being a BHP in a medical setting may come with challenges related to

issues of power. The following is a reflection from one of the authors (Jackie) regarding their experience of navigating identity development as a woman in a medical setting.

As a clinician, my experiences working in the medical setting have been mostly positive. Working with a diverse team has taught me a lot about collaboration and I've been lucky to make several deep and productive connections with colleagues. However, as I reflect on my experiences through the lens of gender, I am reminded of many instances and feelings in which my being female caused additional work for me or made me feel less-than others. One instance involved my work at an integrated care site in which my caseload was dependent on referrals from the doctors. One doctor, specifically, had many patients – but did not work closely with behavioral health. I worked hard to build a relationship with him to improve referrals, and it resulted in me able to have a busy caseload working with his patients. However, an additional aspect of this relationship included enduring his sexist remarks typically regarding patients but sometimes directed at me. Some mornings, when I would check in with him, he would look me up and down and make remarks about how I was dressed that day, often repeating that I was a "tall drink of water." (I am of above average height.)

I tolerated these comments and didn't tell fellow colleagues or supervisors because I didn't want to rock the boat. I didn't want to put my relationship with this doctor at risk as I needed client hours. Also, I had been socialized as a female to ignore these kinds of comments and behavior from men in order to achieve success in professional settings. I have many stories of inappropriate remarks and touching from men in professional contexts, and have had mixed results in terms of speaking up about these acts. Sometimes I was believed, but removed from further career opportunities. Sometimes I was not believed, and felt I was seen as a liability and untrustworthy. While I like to think I would no longer put up with this treatment, I continue to deal with sexism in the workplace.

Though what I experience now is not as overt as in the past, it continues to be difficult to navigate professional life as a female. For example, I once worked with a doctor who did not seem to like answering questions I had regarding technical aspects of medical treatment. I was trying to gain a better understanding so as to help my patients, but it was clear he did not want to take time sharing this with me. I accepted that as him being busy and found other ways to get this knowledge. Later, a new male BHP began working in our clinic and I noticed that he had similar questions to mine, and the doctor would gush about how great his questions were and would excitedly tell him about many of the technical aspects of treatment. This brought a realization that the doctor's hesitancy to talk to me about technical aspects of treatment was potentially personal and related to my gender. Suddenly, I became very watchful of the ways my fellow male BHP was treated in comparison to myself. While my awareness of this dynamic helped me better understand my professional context, I then had more emotional load in my job as I worked to reconcile my gender and how it influenced my professional work.

Over time I have learned to counteract these issues in many ways. In these instances, it's important to find support from others who understand and can help

mentor you in ways to address and cope with the discrimination you are experiencing. However, I continue to find sexism to be wearing on me and causes additional emotional energy to be used to process through these interactions.

As seen from the example above, the status of being a woman can create additional emotional management in a medical context (Lewis, 2005). The same ideas apply to a person of color as medicine often privileges ideas of whiteness. So a professional who is a person of color may be marginalized or oppressed by feeling that they need to fit into white culture. Furthermore, those of a racial minority group may have different experiences and be perceived differently in the clinical environment than that of their peers of the racial majority (Harlow, 2003). Identity Theory poses the argument that an individual's behavior is developed as a result of their conception of self and influenced by the responses of others that are obtained through interaction (Stryker, 1992). Similarly, an individual's identity as it relates to race is impacted by the information an individual receives from their professional peers and/or patients based on the perceptions they hold about their behavior. The conceptualization of an individual's behavior can be perceived differently based on an individual's race.

For example, an individual of color standing firm on a particular opinion may be perceived as combative or argumentative in comparison to their majority counterpart who may be perceived as a confident leader. Persons of color who are entering the medical field are not only positioned from a point of inexperience of which they are trying to overcome, they are also carrying the weight of cultural alienation and possibility the responsibility of creating institutional changes as it relates to the perception of their race. They may take on an added layer of responsibility to prove to others with whom they interact that they do not adhere to negative stereotypes of their race/culture (Cropper, 2000; Granados & Lopez, 1999; Robinson, 1999; Watts-Jones, Ali, Alfaro, & Frederick, 2007). The following is a reflection from one of the authors (Brittany) regarding their experience of navigating identity development as a woman of color in the medical setting.

As a female clinician of color, I am often reminded of my social location and the intersection of my position with those whom I work with. My social location has the potential to positively impact clinical outcomes as I am sensitive to and compelled to attend to the diversity of patients. However, the attention that I often receive reminds me of this country's history of marginalization, discrimination, and racism toward African American people. I regularly experience both colleague's and client's perceptions regarding African Americans as an unexpected topic of discussion in the clinical setting.

One case specifically, I was called in by a resident physician to speak with a woman in her mid-sixties about challenges in her life which were impacting her health. I walked into the room and as I sat down and introduced myself, she interrupted me. The patient began to assure me that my presence in the medical exam room was OK with her and that she was not a racist. She continued to talk about how she takes pride in the Confederate Flag and all that it means for her, her family, and those who live in the southern United States. She explained how this pride should not threaten me as a person of color, as she was okay with working with me.

As I gathered my thoughts, I was left wondering: "If she was okay with me seeing her, why did she feel the need to assure me of this? Why did she defend her stance on the Confederate Flag and her Southern Heritage? What expectations did she have of me that she felt it was necessary to make me aware of her position?" Without answers to any of these questions I proceeded. I chose to do nothing more than acknowledge her sharing and continue providing the brief intervention that was interrupted.

While instances such as these have not occurred with every client that I meet, this in some form or fashion has been my reality in providing clinical care in the medical setting. It has taken me a while to come to terms with my experience of such comments as I'm often left questioning the motivation of clients who say these things. I find myself continuously questioning what my responsibility is to the client, to myself, and to other clinicians of color in these moments. Should I reassure the client, critique them, or further explore their thoughts and feelings in the room? I have not determined a stance with which I am most comfortable. These situations remind me that no matter how far I move up in educational obtainment, or socioeconomic status my race will always have a position in the room, and often speak louder than other points of my social location.

Experiences such as the one previously described continues to make me aware of the implicit biases and assumptions that have been deeply ingrained by the dominant narrative that cannot be escaped and are often a point of discomfort for me. I often strive to have those whom I work with (client, physician, supervisor, etc.*) see me as a competent clinician of color who rises above the dominant culture's stereotypes of African American women.*

While this internal work can be taxing, I can say that I am fortunate to have a team of faculty, mentors, and supervisors who are sensitive to issues surrounding diversity and intersectionality. These individuals work to provided support as I navigate experiences such as those previously mentioned. While I am not sure what my response or position will be in future situations. I have learned to utilize supervision as well as collaboration with colleges to find useful ways to navigate the clinical environment when situations such as these arise.

These are just some examples of how one's social location may influence their professional role and identity development in a medical context. As these examples describe, clinicians of a marginalized group are often tasked with the additional responsibility of being aware of their social identity and how they do not align with the dominant culture. They put extra effort into tolerating unwanted attention or treatment, may experience intrusions or blocks to their clinical work, and must manage how they perceived so as to hopefully be regarded fairly. In these ways, a BHP's performance is expressed through their ability to manage their own internal emotions while maintaining an outward image that is congruent with what they believe others desire to see of them (Goffman, 1978).

Lack of continuity of an individual's social identity in relation to what is viewed as socially acceptable to a larger social context can be a challenge for those in any type of minoritized group. While there is typically an additional level of self-management associated with being a minority, this identity may also provide

positive aspects to the professional role. For instance, individuals may utilize their minority status as a resource to distinguish themselves as individuals who could offer a unique perspective in a clinical setting (Henderson et al., 2018).

Those whose social location sets them apart from what is more socially acceptable may find themselves having a more difficult time integrating and utilizing these parts of their identity into having a functional role in their clinical work. Appearance, for example, has been well documented in its power to impact perceptions of an individual's competence, intelligence, trustworthiness, and perceived work performance (Rosette & Dumas, 2007). For women of color, the appearance of hair has been a topic of discussion of social acceptance in professional environments for some time. Individuals with textured or Afrocentric hair styles are often asked to tame or present their hair in a Eurocentric manner. Clinicians of color who have this part of their racial identity challenged have the difficult decision of how to portray themselves within the professional environment. This creates implications for how they will choose to relate to their work environment or carry out discussions of identity with other clients of color who face similar difficulties.

The perceptions that one has of their own identity has implications for professional identity development. If an individual is uncomfortable with their identity it will impact their perceptions of how they are being viewed by others. Thus this insecurity could, in turn, cause them to question their decision-making ability or cause hesitation to provide input on case conceptualization. A clinician's comfort with their own identity coupled with an encouragement to utilize their unique perspective in the context of interactions with patients can be of great benefit to the healthcare environment. BHPs who come from minoritized backgrounds have a noteworthy perspective and contribution to therapy and case conceptualization. A clinician of a particular minority group may be more sensitive and bring an awareness to how racial identity or felt marginalization can impact the way in which a patient's understands or aligns with their illness experience or attending medical staff.

Implication for Supervision

As clinicians of diverse identities exercise their unique perspectives, it is important that supervisors are available and willing to address areas of diversity and their intersections with illness experiences. Clinicians of minoritized groups, as well as clinicians who utilize cultural awareness and sensitivity to issues of diversity, have the opportunity to utilize this facet of their identity to better orient themselves to the perspectives of their patients. Supervisors should be prepared to assist developing clinicians in navigating the hierarchy of the medical system from the vantage points of their social location. This would require that the supervisor be comfortable discussing the social identity of the therapist within their specific medical context and corresponding assumptions and biases that may accompany this identity. Supervisors should also be prepared to discuss the intersection between the development of

professional identity in relation to the clinician's social location. Helping facilitate an understanding regarding how it may impact clinical work in terms of how they present themselves to colleagues and relate to their patients is important.

Some bodies of literature suggest that supervisors leave discussions regarding multicultural issues up to the supervisee (Bernard & Goodyear, 2009). There may be some benefit to supervisees feeling empowered to bring these discussions to supervision. Supervisors should be ready to engage in these discussions to help the BHP understand and face the challenges that these realities may bring. While other bodies of literature suggest that supervisors who initiate discussions of diversity and power within the context of supervision foster a supportive environment for supervisees which enhance learning outcomes, increase satisfaction in supervision, and promote positive clinical outcomes (Green & Dekkers, 2010). By addressing these points of diversity, intersectionality, and social location in the context of supervision, BHPs will be equipped to navigate the dynamics of the medical setting while also feeling normalized, affirmed, and validated in their skills, role, and experiences (Green & Dekkers, 2010).

As supervisors engage their students in addressing these areas in the medical environment, they should also keep in mind the power and social dynamics that may be at work within the context of the supervisor supervisee relationship. Writings from Cook, McKibben, and Wind (2018) found in looking at the power dynamics of the supervisory relationship, supervisees see the supervisors as the person of power as it relates to setting goals for supervision and providing feedback and support that is geared toward enhancing their clinical skills. This would suggest that it is the responsibility of the supervisor to make the discussion of diversity and the resulting navigation of the medical environment a goal of supervision and provide opportunities for feedback and discussion. Despite social location differences between supervisor and supervisee, conversations around these issues and their implications have the potential to deconstruct stereotypes and normalize interactions that are often difficult to navigate in isolation: To create awareness of intersectionality, social identity, and how they may impact the work of the BHP as they work with their supervisor and/or patients. The following activity will serve as a point of exploration clinician can use to assess their positions on the areas of discussion held within this chapter.

Self-of-Therapist Activity: Oppression or Privileged Narrative

Whether one is a member of a minoritized group or not, it can be helpful to take time to reflect on the social identities that may offer one privilege or oppression in the medical culture. The following questions can be used to help facilitate this awareness:

1. What are your social identities that may offer privilege and/or oppression?
2. How do your different identities offer you privilege and/or oppression?

3. How did you come to understand that you are oppressed and/or privileged? What are some specific experiences related to oppression/privilege that have influenced your professional identity?
4. In what ways does the medical setting influence your identities? In what ways does it contribute to oppression and/or privilege?
5. How do these identities and experiences contribute to your professional identity development?

Once this exploration has begun, it is important to find trusted people to discuss these issues within one's work or academic setting. Whether that is a colleague, supervisor, or friend, better understanding identities and experiences of oppression and privilege, and brainstorming what to do to address them, are essential toward continued professional growth.

Conclusion

Being attentive to the ways in which our current medical system, country, and world may marginalize certain people and populations applies to patients and family members as well as to ourselves as members of the healthcare team. While providing appropriate patient care is one of the primary responsibilities for BHPs, there is merit to discussing how the BHP perceives and understands the intersectionality of their identity in relation to the work environment and its impact on their role. A BHP who identifies as a member of a marginalized group can offer a much needed perspective and provide contributions to the healthcare system at large. Helping to address inequities for the BHP can be a step toward creating a medical environment that sees and respects differences for all.

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Resources

AHRQ Health Literacy Universal Precautions Toolkit. https://www.ahrq.gov/professionals/qualitypatient-safety/quality-resources/tools/literacy-toolkit/index.html

Behavioral Health Equity. https://www.samhsa.gov/behavioral-health-equity

Cultural Competency assessments/quizzes. https://guides.lib.uiowa.edu/c.php?g=131924&p=864758

Culturally Effective Care Toolkit. https://www.aap.org/en-us/professional-resources/practice-transformation/managingpatients/Pages/effective-care.aspx

Georgetown University National Center for Cultural Competence Self-Assessments. https://nccc.georgetown.edu/assessments/

Glossary of Terms Related to Gender. https://www.hrc.org/resources/glossary-of-terms

Burnout and Fatigue

Max Zubatsky and Jackie Williams-Reade

Burnout is described as a condition based on the protracted depletion of an individual's energies (Shirom, 1989) and is characterized by emotional exhaustion, lower personal accomplishment, and feelings of insufficiency and depersonalization at work (Houkes, Winants, Twellaar, & Verdonk, 2011). Although there is no unified definition of burnout in either the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM-5), many consider burnout to be a mental health impairment (Korczak, Huber & Kister, 2010). Work-related stress has been recognized as one of the largest predictors of mental health and family conflict issues in Western society (Rosa, 2014). Approximately 21%–67% of mental health professionals experience high levels of burnout in their current work environment (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). BHPs working in medical settings are starting to experience these same rates of burnout and compassion fatigue in their services provided to patients (Dyrbye et al., 2017; O'Connor, Neff, & Pitman, 2018).

The concept of burnout can be viewed differently from those who experience compassion fatigue in their work (Canfield, 2005; Dunkley & Whelan, 2006). Both terms overlap in that the professional has emotional burdens and exhaustion as a result from patient-related issues. However, burnout often stems from a lack of personalization for patients and staff while compassion fatigue is usually a residue of exposure to working with high-risk situations or health conditions that burden the provider over time. For new therapists entering these training settings, supervisors

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should consistently be aware of the risks that both situations may pose. Signs of burnout might be seen as low motivation levels or signs of apathy toward the value that the job provides (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012) whereas compassion fatigue might be an indication of a provider lacking appropriate support and connection for the patients, families, and cultures in their practice.

Burnout can affect new trainees who are entering medical settings and environments for this first time. Those new to the helping professions may be especially vulnerable to the risks of burnout as they may not understand the emotional and professional demands a healthcare position entails. Career choice satisfaction may be a large contributor to how students perceive potential burnout in future healthcare positions. Thus, a larger mental health workforce in medicine may be stalled due to the perceived stress and job burnout that students possess (Kovach Clark, Murdock, & Koetting, 2009).

Perspectives of Burnout in Healthcare

Certain instruments and frameworks have viewed how burnout should be measured in healthcare. The Maslach Burnout Inventory (MBI) is perhaps the most recognized and widely used scale to determine burnout areas of mental health professionals (Maslach, Jackson, & Leiter, 1996); Maslach and Leiter (2008). Aspects of depersonalization, personal accomplishment, and emotional exhaustion are conceptualized as low, moderate, or high levels of burnout in one's work environment. One shortcoming of the MBI is that the validation of the scales comes from several organizations outside of the healthcare field. Additionally, there are current demands in healthcare that were not fully present 20 years ago, such as increased managed care challenges, operational pressures of work productivity and increased committee roles for BHPs in care settings.

A widely used questionnaire that measures compassion fatigue and professional satisfaction is the Professional Quality of Life Scale (Stamm, 2009). Supervisors and administrators can use this evaluation to determine the positive and negative qualities that trainees and providers feel about the quality of their work. The questionnaire has been used extensively in the nursing field (Lauvrud, Nonstad, & Palmstierna, 2009; Lee, Dai, Park, & McCreary, 2013) where large patient caseloads and the psychological impact of impatient settings cause significant burnout and compassion fatigue over time.

Others have applied social exchange theory to burnout (Schaufeli, 2006), where people who invest in relationships should gain a proportional return. Sometimes, the time and resource investment does not pay in certain rewards. The lack of this reciprocity or unbalanced relationship often drains a professional's emotional resources, which can lead to emotional exhaustion. For healthcare professionals, many offer their services, skills, and personal time to improve the health and well-being for patients. When many of these efforts at work are not appreciated or taken for granted, an increased sense of hopelessness, depression, or personal accomplishment can set in. Administrators are starting to take note of these reciprocal processes, where healthcare employee burnout is rising due largely to the lack of support for

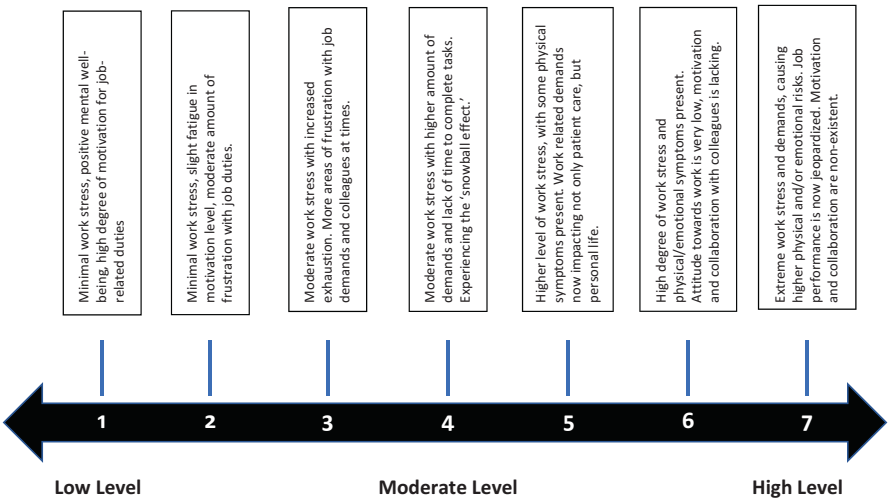

Fig. 1 A spectrum of burnout for behavioral health providers

the job and professional demands they face (Morse et al., 2012; Shah, Kapoor, Cole, & Steiner, 2016)

We view burnout as a spectrum of levels and combination of personal elements (see Fig. 1) rather than a binary construct, where someone is either (burned out or not burned out) based on a total score. Providers can still function effectively at low levels of stress or burnout without major impact on work productivity, patient care or team rapport. In fact, some low-level burnout is expected during times of intense rotations or clinical demands. For instance, a therapist supervising students or residents on a hospital rotation may encounter several high crisis cases. The challenges of patient care, coordination with medical departments, documentation, and finding resources for several patients would be exhausting even for experienced BHPs. Although this provider may have a lower level of burnout, this job stress does not necessarily warrant mentorship, remediation, or possible counseling. When providers start to climb up the ladder of higher burnout, one may look into peer consultation groups or other forms of mentorship to curb these emotional and physical risks. Supervisors should routinely explore 'self–of-the-therapist' areas of the supervisee, processing personal characteristics that might be challenged in a medical environment. (Such as confidence, rapport, competency in medical terminology, and reactions to patient's stories and narratives).

Cultural Factors Related to Burnout

The concept of healthcare burnout crosses over to several cultures in the world. Where research has normally focused on physician burnout (Dugani et al., 2018; Salyers et al., 2017), other healthcare providers are starting to report similar rates of work burnout and work-related stress. Family history and cultural backgrounds can

largely shape how one handles the stresses and demands of high workloads. As behavioral health providers are assuming more healthcare positions across the globe, the increased time pressures, caseloads, and job demands appear regardless of the geographic location of the organization (Bria, Baban, & Dumitrascu, 2012; Lo, Wu, Chan, Chu, & Li, 2018).

My (Max's) experience of determining burnout around work boundaries was greatly influenced during my primary care training in my doctoral program. During this internship period, I had diverse colleagues who were also training students from different programs. A Hmong colleague of mine made sure to prioritize her work schedule only within the clinic hours during the week. She placed a high precedence on family life and family rituals during the week, where the balance in other job duties and requirements would get addressed on her terms. She also needed to make sure that her emotional and physical well-being were adequate as she was caretaking for an ill family member at the time. As a white male, my colleague's priorities made me reassess the boundary setting that is needed for a professional to set where family and cultural perspectives of work can serve as a buffer to potential burnout. At that time, I was an overworked therapy intern where my background taught me to commit fully to your job no matter what it takes. My obsession to gain clinical hours and overextend my job duties took away from other personal areas of my life. By scaling back these commitments, I learned that my self-care and work–life balance made a significant difference in the outcomes of the patients.

The following case examples depict another way in which cultural values and norms can influence professional boundaries and the potential for compassion fatigue of patients.

Case Scenarios

Salima, a 37-year-old female from Pakistan, attends a rural university for her doctoral program. She is interning at a rural primary care practice in the Midwestern United States and has a special interest in refugee and immigrant populations. Her graduate courses and additional trainings have made her a very competent provider in this field. One of the physicians in her practice wants Salima to get referrals for patients with abuse histories related to chronic pain. The first two patients that she saw around trauma issues were able to effectively process their grief experiences in sessions and felt comfortable in the room with a therapist. However, several subsequent patients began to refuse treatment from Salima, many claiming that they did not want to see a therapist for their problems. Salima heard through a few providers that patients shared their fears of seeing a Muslim woman in the clinic. In a predominantly Caucasian town, Salima was not only stigmatized by patients, but also the community that she lived in. Salima realized that wearing her hijab in the clinic might be making some patients feel uncomfortable. She started to question not only her work, but how effective she would be as a therapist in general. She became more isolated at work and tended not to show her face to patients in the

lobby. The staff noticed this and began to be concerned about Salima's perception of the clinic and her role in the practice.

Over the next couple of months, Salima continued to struggle with comments that patients would say about her. She began to show frustrations with a few patients, where even their curiosity and questions about Salima's culture would aggravate her. Midway through her internship, she started to notice more apathy and depersonalization toward patients in the practice. She now internalized her frustrations that most patients would not accept her cultural differences. It took Salima several supervision meetings to process her "self-of-the-therapist" issues and feelings around her worth in the clinic. Her supervisor made sure that Salima could attend team meetings and more social outings to be part of the team and feel a greater acceptance in the community.

This situation presents a cultural dilemma for the intern that can be very challenging to navigate. In many training sites and geographic locations, aspects of cultural and religious biases unfortunately arise. Salima would benefit from increased supervision from both her site supervisor and current graduate program. The graduate program and site might need to talk and discuss options for Salima to feel comfortable in her work environment and feel supported by the clinic staff. Physicians, nurses, and other providers should be made aware of the comments from patients and where their communication with patients during handoffs and consults could increase awareness and support. If the situation were to continually remain problematic, the graduate program may look at either relocating Salima to a different training site or shift the role for her services in the clinic. Examples of this shift in roles may include having Salima serve as a liaison for families, shadowing physicians during encounters for additional training or handling crisis calls that come to the clinic.

Diego is a 44-year-old Latino male who identifies as gay. He is a newly licensed therapist and assumed a position in a community mental health clinic. He has taken on multiple responsibilities in his clinical and supervisory work and has been asked to serve on the healthcare board of their organization. Diego has had a difficult time saying "no" to certain bosses and administrators, since they know how hard he has been working so far. After months of overcommitting his schedule, several things start to get ignored. The most glaring issue is that patients have complained about his missed appointments or not being able to reach Diego. Diego was so alarmed by this news, that he started to book after hours appointments three days per week to make up these clinical times. As a result of overscheduling his weekday appointments and meetings, Diego's sleep and health have been affected greatly. He was hospitalized six months into his job for dehydration and extremely low potassium levels. Even after being discharged, he felt a sense of disappointing his staff and colleagues for not doing enough in his work to meet demands in the clinic

His clinical supervisor made it a priority that Diego creates a wellness plan transitioning back to work. Diego was very surprised in the support that he received from the care team. He did not realize that others in the clinic were somewhat concerned from his overcommitment to tasks and how much burnout he was experiencing. As the year went along, Diego took part in more wellness workshops, as well as creating a quarterly workshop for medical assistants, nurses and front desk staff.

The hospitalization was a wakeup call for Diego that he had to make boundary setting a key priority in his scheduling and professional work.

Burnout can often arise when a provider feels that they need to prove their skills and worth above-and-beyond the call. In this case, Diego has placed himself in a role of continually trying to please colleagues and staff by taking on every role and volunteer position. The lack of boundaries around trying to protect one's self-care can lead to increased risks of emotional, physical and family problems. Diego needs to feel comfortable saying "no" to several commitments at his work with support from a supervisor or administrator. Additionally, someone at his work may need to mentor Diego around his boundary setting with some close monitoring of his balance of job responsibilities moving forward.

John is a 63-year-old that has been a Behavioral Science faculty member for 17 years in a residency program. Recently, his wife of almost 35 years passed away from breast cancer. John continues to work in the residency because it is close to his brother and a good friend. He has been getting good support from colleagues and mentors. One of John's responsibilities is to educate and supervise residents on their behavioral health rotations. A few of them have taken an interest in families with a cancer diagnosis and using psychotherapy skills with this population. After a few weeks of shadowing residents on this rotation, John has become very affected by the cases that he has seen through his supervising. He began going home emotionally exhausted and crying at times when remembering his wife. As John began to work with more chronic illness cases the next several weeks, the flooding of emotions from the loss of his wife continued. He has become more distant from educating and teaching residents on this rotation as a result of the personal issues that come up in his work.

In this case, the therapist is experiencing self-of-the-therapist issues that is affecting both his personal and professional life. Burnout and personal struggles can happen not just with beginning therapists but in advanced careers as well. With seniority in the job, it is sometimes common for supervisors to operate their self-care issues alone. Although John is receiving support and comfort from colleagues, there are clear grief issues that are triggered by some of the clinical rotations that he is working on. The residency program might want to support some time off for John, getting away from the stresses of work. His supervisor or boss may also want to support John seeking help for his grief and put supports in place so that the program could help him with any work-related issues that may trigger his grief reactions.

Strategies to Combat Burnout for BHPs

Resiliency strategies for burnout and burnout prevention should ideally come from all levels of a healthcare setting. Without support and systems in place to help the BHP through their work, the therapist is forced to operate on an island regarding their personal self-care and validation for their work. The following are strategies at

three levels of healthcare roles that can help mitigate some of the burnout and fatigue factors that often arise in early career professionals.

Behavioral Health Providers

- *Consider self-care activities.* BHPs should have a range of self-care strategies that help them get away from the weekly demands of the job. Activities should ideally be non-related to work and help professionals find areas to help improve overall wellness.
- *Target motivational and intrinsic goals.* Whether one is an intern or a long-time therapist in a healthcare setting, setting up motivational goals and aims is a way to stay engaged in their work. Goals should also be intrinsic in nature where the work achievements are gratifying for the purpose of the job itself.
- *Interprofessional skill development.* Therapists can learn ways to interact more with their team and get support from colleagues about their skills. Often, burnout can lead to increased isolation from colleagues and the treatment team.
- *Personal retreats/mental health days.* BHPs can benefit from taking mini retreats whether for self-care or creating more of a life balance outside of work. Therapists should reward their hard work with these periodic retreats to re-charge their motivation and interest levels in their work duties.

Support from Supervisors and Mentors

- *Increased emphasis on evaluation of self-care.* Supervisors would benefit from incorporating self-care strategies in their periodic evaluations of trainees or staff. Making this a priority in the evaluation process allows for new therapists to develop self-care skills during their training period.
- *Involvement of more care team activities.* One way to increase confidence and support for trainees and supervisees is to engage them in more team-based activities or meetings. A colleague or provider could have the trainee shadow or sit in certain clinical huddles or patient rounds to get increased exposure to the team and greater support.
- *Strength-focused feedback.* Often, supervisors are quick to notice the deficits in trainees and new healthcare interns. Increasing the number of strengths for trainees is a way to build one's confidence and highlight hidden areas of work that have been productive.
- *Preventing overcommitment from interns.* Sometimes, a new clinician who is burning out from the medical environment will need periodic breaks. Supervisors and mentors should also monitor that new professionals do not overcommit to committees, groups or other outside tasks from their clinical roles. The supervi-

sor should continually monitor which clinical activities and rotations might be too heavy on the intern during periods of burnout.

Support from Administrators and Organizations

- *Greater appreciation of job accomplishment.* Providing employees with periodic emails or letters about job work and accomplishment can help curb some self-doubt of providers.
- *Safeguards to address burnout in the workplace*. Administrators need to consider ways to reduce overworking and outside demands for BHPs. Clinics, hospitals and other settings would benefit from having process groups or in-service talks about work satisfaction and areas of burnout.
- *Increased resources and support systems.* For all providers (including BHPs), having multiple resources or supports in place when burnout arises is essential. BHPs should feel like they have a work environment that supports time to seek therapy, groups, or other community forums that help combat work fatigue or personal issues.
- *Wellness days for clinical teams and staff.* Healthcare settings that create wellness days or retreats allow employees to bond with colleagues on a deeper level. This also shows the organization's commitment for looking out for the well-being of providers and emphasizing a team-oriented environment.

With more healthcare providers required to meet professional demands in the context of their work, burnout and compassion fatigue will be an ongoing challenge for organizations and clinics to address in future generations (Lamson, Meadors, & Mendenhall, 2014). While the development of process groups, support systems, and scheduled work activities has helped curb some of this trend, the unpredictable nature of both workload and patient hours in medical settings impacts work–life balance. New trainees and students would benefit from practicing wellness habits and boundary setting during their rotations and internship years. Learning these skills early in training can help protect individuals' time for family, cultural rituals, hobbies, and other life necessities. Without these safeguards in place for the next workforce of BH providers, fewer incentives will be offered for aspiring therapists to enter work in the medical field.

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Practice Challenges and Ethical Decision-Making

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During my (Max's) doctoral training, I came across a situation where a chief resident was describing a patient in a very unprofessional manner. The resident was clearly frustrated with the patient's lack of motivation around their health, shaming the patient's weight in front of his colleagues. As I was hearing the conversation in the huddle room next door, my anger rose very quickly. The resident then proceeded to mock the family's weight, joking about their health habits. A challenge for confronting this resident that day was that there were two encounters that demanded this person either be consulted on or part of the team visit. I was advised to wait until the following week to process these feelings with the resident. Although the conversation was not easy to initiate, I learned that there were deeper issues present that impacted the resident's views of the patient. Through a few more follow-up conversations, there were some cultural aspects of the patient that I brought to the attention of the resident. These were blind spots in the resident's training that were not indicative of his clinical competencies but rather lack of cultural awareness of the population he was serving.

When working in the healthcare field, one will always come across several practice and ethical challenges that tests one's moral compass. These situations not only pertain to patient issues but to colleagues and the entire organization (Bazerman & Tenbrunsel, 2012). A new therapist often does not recognize or anticipate these challenges that will arise during their training, largely due to entering a new context

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with unknown roles and responsibilities (Curtis & Christian, 2012; Hall et al., 2015). Although most ethical issues can be largely avoided, BHPs face a tougher challenge when the ethical conduct applies to a work partner or friend in the workplace. What is described in this chapter are real-life ethical dilemmas and practice situations that pertain specifically to therapists working in medical and healthcare settings. These issues not only affect how the therapist responds to patient care, but how one handles internal conflicts that push their decision-making and morals to different places. As a White male, I have increasingly focused on the areas of power and privilege within the context of care in medicine. I also have worked on how my personal ethics, morals, and beliefs might contradict other colleagues' perspectives, where learning to navigate and negotiate this terrain is always an evolving process.

Ethical decision-making is often seen as gray area for professionals working in medical settings. Whereas providers know the appropriate legal steps after a patient states a plan for suicide, navigating through challenges such as power and privilege, cultural sensitivity, and best clinical practices become less concrete (Thompson et al., 2016). Ethical decisions in healthcare require that BHPs consistently make sound decisions that help protect themselves, their care team, and the patient. Training programs often lack the necessary preparation for new training interns and students for situations that require immediate decision-making in medical settings or appropriate times to consult around a clinic issue (Bischoff, Springer, Reisbig, Lyons, Likcani, 2012; Hall et al., 2015). When BHPs get thrown into these tenuous situations, many often struggle with navigating the appropriate action or steps in a new setting.

Common Ethical Dilemmas for Therapists in Practice

Those who chose to practice in healthcare settings must anticipate potential ethical dilemmas. Some of these situations are inherent challenges within the medical system, whereas others test the moral compass of therapists in their everyday practice. Practitioners always need to be aware of adhering to their code of ethics in a given discipline (Bazerman & Tenbrunsel, 2012). Often, there are gray areas of practice and professional work that place therapists in tough spots to make confident decisions. Unlike many traditional psychotherapy practices where a therapist may operate as a solo provider, addressing practice challenges on collaborative teams requires skillful navigation on the part of the BHC (Curtis & Christian, 2012; Robinson & Reiter, 2016). The following are some ethical issues that often come up for clinicians and present both moral and ethical dilemmas.

Informed Consent

Just like in routine psychotherapy services, medical clinics and organizations have protocols for informed consent of services for patients (Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002). Hospitals have become so efficient at collecting con-

sent that a "blanket" consent will often cover the communication and information provided from multiple providers in the patient's care. Consent becomes a trickier process when the BHP provides quick consults or warm handoffs from physicians where the conversation may not warrant a patient encounter (Hodgson, Mendenhall, & Lamson, 2013). However, do patients know the scope of your work and goals of your services even in these brief conversations? Do patients know the scope of psychotherapy services even if they are not established patients? These areas should not be glossed over in appointments even if patients may be seen for a one-time consultation or encounter.

Therapist may need to revise their policies for how their clinics and practice settings manage informed consent around all types of mental health services. The patient needs to be aware of their control of the treatment process and their rights of not having to see a BHP if requested. BHPs should also make it a routine practice of explaining their role to patients and their understanding that they might be engaging in a behavioral treatment or intervention. Providing verbal consent to patients and families may be necessary in times where sensitive issues or topics may have to be addressed in appointments. Any safety or risk issues such as self-harm, partner violence, or previous traumas often warrant permission from the patient to speak on these issues in front of family or other friends.

Addressing Medical Errors

One of the most challenging and humbling experiences of new providers of any discipline is to admit your mistakes to patients and/or family members. The admission of a medical error not only takes a certain amount of humility but a willingness to use the patient's frustrations as a learning experience (Khoo et al., 2012; Mazor, Roblin, Greene, Fouayzi, & Gallagher, 2016). Therapists often do not realize that they may be brought into these conversations, especially during work in hospital or inpatient settings. Families may direct their frustrations to behavioral health providers on physician errors around failure to report test results, missed diagnoses, or medication errors. The BHP must decide how to not only bring this information back to the provider, but how the care team will negotiate this error with patient and/or family.

If you are in a situation where a mistake happened, showing a clear sense of compassion and forgiveness of the situation is a top priority. This should be the case regardless if the BHP was part of the initial error. BHPs are a part of the team in which patients may view the scope of a problem as the fault of the entire set of providers involved. The therapist's interpersonal skills can help repair and find resolve for the patient or family during these conversations. Nevertheless, the medical team, specifically the provider at fault for the error, has a legal responsibility to discuss this error with the patient and/or member in charge of their health decisions (Khoo et al., 2012; Rosser et al., 2005).

Secret Keeping

Medicine can be a very vulnerable place for patients to disclose their information about personal health, emotional, or family issues. Often, there is an internal script that patients carry regarding what their providers might judge them by as a result of a medical issue, lifestyle choice, or healthcare decision (Rolfe, Cash-Gibson, Car, Sheikh, & McKinstry, 2014). Although BHPs are trained to be open about discussing a range of clinical and personal patient topics, situations get complicated when the BHP is requested to hold secrets. Patients might triangulate therapists into making sure that their doctor or specialist does not know about a confidential issue or situation in their lives.

For instance, a patient may have multiple sexual partners and recently contracted an STI. This patient confides in you not to tell their physician, in hopes that the physician will not think badly of them or shame them for not adhering to safer sex practices. As the therapist, it is important to explore the patient's hesitation to keep this issue a secret from the physician and, possibly, other care providers. Also, BHPs have the responsibility not to withhold important health information from their care team. The aspect of secret keeping needs to be highlighted to the patient in this appointment and outlining the risks of withholding this information for more time (Richards, 2009).

Boundaries Around Scope of Practice

All mental health professionals adhere to a scope of practice as part of their code of ethics. This parameter allows therapists to work within the bounds of areas such as diagnosis, assessment, treatment interventions, and types of services that can be provided. In health care, therapists often work with patients where overlapping medical and medication concerns are present (Bischoff et al., 2012; Edwards & Elwyn, 2009). BHPs ride a fine line between therapeutic conversations of medical and pharmacological issues and giving straightforward medical advice of decision-making of one's condition or illness (Hall et al., 2015).

It is important for therapists to be consciously aware of their questions, curiosities, and treatment recommendations for patients around health and medication issues. Therapists might be put on the spot to give advice about a particular antidepressant medication or decision about getting a particular procedure done. A new therapist should not feel insecure about their lack of knowledge of a topic or condition but rather refer the patient's questions to their current physician or specialist in that area. For example, patients who have a history of failed response for antidepressant medications are recently prescribed a new SSRI for depression. Although a BHP cannot give direct advice about stopping or readjusting medications for depression, they can provide elements of psychoeducation of the risks of withdrawing their medication early. Additionally, the patient can receive some behavioral strategies to help improve their mood while deciding how dedicated they are to take their medication.

Reporting Unethical Behavior

Unethical behaviors and situations can range on a large spectrum in healthcare settings. Some situations may involve a colleague talking bad about a patient or colleague in public. Extreme situations may involve provider–patient relationships, falsifying documentation in charts, or overcharging for procedures and codes that add to large amounts. Whatever the case, therapists can often be placed in the uncomfortable role of reporting inappropriate behaviors of colleagues and other staff. These situations place a high degree of anxiety and vulnerability on the part of the BHP, where the risk of fracturing close relationships with a care team is a possibility.

Several factors can go into one reporting or bring up an unethical issue in their practice setting. New BHPs should have a decision-making process for how one would go about addressing this issue and to which providers. Therapists in training should also have a conversation with their supervisors about how to go about a situation in their practice setting, should something arise. More experienced clinicians can benefit from having good rapport with their administrative staff in case of any unethical conduct that needs to be communicated or processed.

Family Decision-Making/Power of Attorney

In certain medical situations, families will have to make very difficult choices around their loved one's health. For end-of-life patients, family members not only reorganize their priorities around the person's care but also honor the wishes of the patient during hard circumstances (Yadav et al., 2017). In hospital settings, a family without a designated power of attorney (POA) may have to choose who will assume this responsibility and decide whether the member gets a "full code" for procedures to be continued to keep the patient alive. Some families not only lack a POA for their loved one but have trouble understanding the definition and responsibilities of this role. The BHP and healthcare team have a responsibility to not only educate the family about a healthcare POA, but process any cultural, spiritual, or familial areas that impact the family's decision to determine their loved one's health.

Therapists must navigate a difficult path with families concerning end-of-life issues and scenarios. These conversations may take the form of family meetings in a consult room in the hospital or in a larger conference room in a primary care clinic (Curtis & Christian, 2012). Often, the BHP will gather all members' perspectives of the POA issue and help families best negotiate what is best for the patient (Milte et al., 2015). Despite who takes the legal responsibility to be the executor of healthcare decisions of the patient, the therapist can skillfully find ways for the family to be involved in the care moving forward.

Access of Services by Minority Populations

Patients from underserved or underrepresented populations are often challenged to get adequate healthcare services and coverage. This population not only underutilizes mental health care services (Wilson & Schild, 2014) but often has strong cultural or personal values that go against the use of these services. Additionally, the power dynamics of a doctor or other health specialist to request mental health services may place minority groups in a submissive role when making decisions about their care. Therapists should consider the culturally sensitive nature of minority populations in practice. BHPs have to be sensitive in offering services at an affordable, cost-effective rate for patients and families, all this while administration and operations may put increased pressures on productivity and revenue generation of their job. Certain social determinants of health should routinely be assessed in healthcare settings to gain a fuller scope of the patient's barriers to care (Cunningham, 2009). Areas such as housing, transportation, access to medication refills, and family supports make a significant difference in how often patients follow-up with their care team.

Case Study

Jasmine is an African American female in her late 20s and started practicing in a primary care clinic for her doctoral fellowship. Because she is the only behavioral health provider on the staff, she has garnered lots of referrals and consultations around the clinic. Her director has already seen the impact she has made in improving patient care and coordination with other colleagues. Dorothy, one of the nurses on her team, has been going through some difficult personal struggles in her life. She recently lost her husband to cancer and is currently living with her mother due to financial problems in the family. Others in the office have noticed a considerable change in mood in the last three months. Although her director has suggested that she take a leave of absence, Dorothy is insistent on continuing to work because it takes her mind off of the stressful events in her personal life.

One day, Dorothy knocks on Jasmine's office door and needs to talk to someone. Dorothy confesses to Jasmine that she is really going through a difficult time and needs to borrow some money. She promises to pay back Jasmine and to honor her word. Jasmine says that she would need to think about the situation first before making any rash decisions. Later that week, Jasmine gets an email from her director at the clinic. The director feels that Dorothy would benefit from seeing Jasmine on a periodic basis to talk about her mental health issues. The director would also be open to Jasmine touching base with him about any updates from Dorothy from these consultations. Jasmine now feels like she is in a bind, wanting to help Dorothy without making their professional relationship compromised.

After a few consultations with her supervisor, Jasmine decided to have a brief meeting with Dorothy in a separate office in the clinic. Jasmine expressed her wor-

ries about seeing Dorothy as her therapist and exchanging money where these issues would present a boundary issue for Jasmine. Jasmine also expressed that she did not want either situation to affect their professional relationship, considering that they work collaboratively on many of the same patients. Jasmine encouraged Dorothy to talk with her boss about the financial issue to see what other resources or supports could help. Jasmine's supervisor had a follow-up conversation with the clinical director to clarify Jasmine's decision not to be Dorothy's therapist and how this role could pose a dual relationship problem going forward.

This dual relationship dilemma is becoming increasingly common in health care settings. It is commonplace for physicians to treat staff and other providers as part of routine medical care. The ethics are different, however, for behavioral health services provided to professionals in the same clinic. Jasmine was caught with the dilemma of wanting to help a colleague but without jeopardizing the ethics of a dual relationship with someone in her same practice. The merging of medical and behavioral health fields in integrated care practice has been one of the biggest challenges in regards to confidentiality of the care team. Jasmine should realize that although her director feels that Dorothy would benefit from periodic consultations for her emotional issues, this would blur the work boundaries even further. Additionally, Jasmine must navigate the hierarchical structure and gender issue of confronting her director about this dilemma. Her conversation with the director should not only take Jasmine's perspective into account but an opportunity to educate the director about the ethical differences between medical providers and behavioral health providers. For a new intern, this can be a very difficult position to face, given the need for Jasmine to gain trust and connection with her care team at the start of her rotation.

Practice Challenges in Routine Care

In addition to ethical concerns and dilemmas that happen within the scope of medical practice, there are practice challenges that BHPs need to consider in their settings. These challenges can often deal with space, communication with the patient, and/or understanding of health concerns and cultural considerations in clinical encounters.

- *Office space and practice locations.* In many clinics, the BHP will not always see the patient or family in a therapy office. Sessions can be conducted in an exam room, conference room or common room that is shared by other providers. Anticipating interruptions and overhead pages are a common distraction in sessions. Additionally, these settings may not have the most comfortable seating options for patients and/or members to have during a longer session. When the BHP does not have the resources of a traditional office, he or she must adjust their style of therapy to align with the presenting problems of the patient or family.
- *Gender issues that may arise during an encounter.* Patients often have challenges disclosing certain personal information due to the gender of the physician

(Bertakis, 2009). BHPs may be brought in for consultations to help alleviate these concerns of patients and/or family members. In the hospital settings, BHPs routinely encounter such examples, where the pace of the conversation, sensitivity to the gender-specific issues and volume of speech needs to be altered to adjust to the patient's situation. Some examples of sensitive gender issues may include partner violence, sexual dysfunction issues, or previous trauma-related conditions.

- *Confidentiality in the hospital setting.* Another challenge on inpatient services is the lack of true confidentiality when speaking with patients. The patient might be sharing a room with another patient or have an exposed room where those in the hall might be able to hear (Hodgson et al., 2013). Nurses, medical assistants, specialists, and other providers will frequently enter the room at unexpected times and unintentionally interrupt the conversations. Therapists should remind the patient about the possibility of the conversation being open for others to hear and handling ongoing disruptions in rooms.
- *Health literacy and health education.* A major shortcoming that health care providers continue to overlook is the literacy and education of patients surrounding their healthcare decisions (McCune, Lee & Pohl, 2016). Aspects such as socioeconomic status, race, ethnicity, age, and educational level can make a large impact on how patients manage their health issues. Many patients struggle with knowing how to organize medications, read labels and information, understand complex medical terms, and complying with a long-term treatment from a provider. When BHPs offer an intervention, skill, or technique for the patient to consider, one should also assess for the patient's level of understanding this recommendation and what supports could help with the follow-though of the plan of care.
- *Using interpreters for sessions.* Some patients, for whom English is a second language, may need an interpreter (in-person or phone) to help translate sessions. Therapists should consider ways to adjust their conversations in these types of sessions (Jacobs, Ryan, Henricks, & Weiss, 2018; Kalina, 2015). The pacing of questions and time allowed for translation to be communicated back to the therapist is a learning curve for many new therapists. BHPs must also be sensitive to any cultural issues in how questions are answered and how the interpreter constructs the information going two ways.

- One specific case stands out for me (Max) around the issue of interpreters and health education.

This example occurred when I was rounding with a family medicine team in a hospital. A Puerto Rican patient and her mother were in the room with five providers on the family medicine team (one BHP, one physician, one medical resident, one pharmacist, and one case manager). The physician was Spanish-speaking and willing to interpret the conversation for the patient, mother, and medical team. When the doctor began to ask questions, the patient's mother became increasingly frustrated. The mother interrupted the physician and said, "You are speaking the wrong kind of Spanish." The patient asked the physician if she could call the interpreter to finish

the conversation. Although the physician was respectful and supportive of their decision, the encounter extended an extra 15 minutes because of locating an interpreter, allowing translation time, and processing all the patient's concerns. The patient also reiterated to the physician and team that her mother does not understand all of the medical terms and medications that the other doctors have discussed. The physician was very brief with the mother and left the room to attend to other patients on the floor. The pharmacist and resident spent an additional 10 minutes going over the list of medications and what they are used for.

After the team finished rounding, both the therapist and team went back to the room to process any concerns or questions they had. The patient said that she was appreciative that they heard her concerns and did not like the tone of the previous physician. This also became a learning experience for the residency team where they had to admit as a group that they did not hear the family's concerns effectively. Respecting the culture and language of patients and family members in the hospital setting is a very important competency for all health care providers. BHPs often have this role of listening to patients' frustrations, concerns, or opinions as a result of decisions made by the care team.

Conclusion

Legal and ethical considerations will always exist for mental health professionals who work in interdisciplinary settings. While each professional discipline has their own code of ethics to follow, many ethical challenges in medicine are considered new territory for beginning therapists in their training or career. Even more unknown ethical decisions and challenges exist for BHPs in secondary and tertiary care settings (Bazerman & Tenbrunsel, 2012). As the roles of therapists expand in an ever-changing United States health care system, the work tasks, scope of practice and autonomy of decisions will continue to be an evolving issue moving forward.

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Professional Perspectives of the 'Self' in Their Journey Through Medicine

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The value of mentorship and collegial support for beginning interns, therapists, and graduate students in medical and integrated care settings cannot be understated. When challenges or unexpected encounters arise, having strong supports from faculty supervisors, directors, and colleagues can help one manage these hurdles more effectively. The mentoring process often parallels the process of therapy where both parties learn to feel comfortable with the quality of conversations while strengthening trust in the relationship over time. Mentors are not just supervisors, but educators, models, and confidants to learners in new training contexts

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(Prouty, Helmeke, & Fischer, 2016; Prouty & Storm, 2014). Effective mentors also introduce the professional culture of medicine to new professionals while providing a buffer to some of the common operational and structural challenges in a clinic or organization (Paris & Hoge, 2010).

Each of us (Max and Jackie) learned the value of acknowledging "self" in our training through many professional experiences. Unexpected clinical situations and difficult patient encounters made us attune to how our family of origin background affects our perceptions of certain mental health and medical conditions. These encounters also reminded us of how critical power and privilege comes into play from the provider side, stressing how we must continually check on this social status in our work. Different styles of supervision and mentoring allowed us to gain unique perspectives of not just patient care but how to function effectively in a new medical environment. We both arrived at helpful self-care strategies during times of rising burnout, lack of personal hobbies and family time that created the necessary life balance outside of our work. Regardless of the path that each professional takes to work in the medical field, we all create a journey that is unique to our own and make personal discoveries that are often never found in a textbook or the classroom.

The following are personal narratives presented from four professionals in the field who have worked in a variety of health care settings. Their reflections highlight specific personal and professional topics that have impacted their growth as a clinician and demonstrate how their own "self of the therapist" issues were processed during these experiences. These professionals offer sound advice to future learners and new professionals as they embark in new practice and training settings.

Knowing the Story Is Not the Same as Knowing the "St-o-o-o-ry"

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The stories we tell when ill and their meaning have gained my attention and curiosity since I was a young boy as my parents both worked in hospitals. My father was the director of the physical therapy section in the only local public hospital dedicated to people who had work-related injuries and my mother was a social worker in a public adult and pediatric hospital. They took me to their respective workplaces during the summer school break from ages 8 to 12. I was in the occupational therapy unit when I went to the hospital with my father and was assigned to do small building projects with my hands, like the ones that patients were doing. The difference in purpose between the patients and me was that I was doing the projects for fun and they were doing theirs as part of their injury's rehabilitation.

Initially, I was a curiosity in the unit. Patients were in the rehabilitation unit because they had a work-related injury frequently causing to lose a body part or a neuromuscular impairment, whereas I had no injuries. Their building projects were

designed to help them rehabilitate and my projects were for fun. However, despite our differences, the patients embraced my presence in the unit and I gained enough confidence to ask them about their injuries. Usually, I began with a simple question, "How were you injured?" The patients not only told their stories about how they were injured, but about their lives, families, hopes from rehabilitation, regrets, pain, challenges, and how they were coping. I remember listening with curiosity to their stories the whole day. These experiences, without me knowing at that time, led me to develop fundamental empathy for a person experiencing adverse health problems. I gained an interest in knowing more about the person by deeply listening to their stories, which revealed the fundamental meaning making of their worlds and style of coping during adverse situations.

Going to the hospital with my mother provided a different experience. Here, I listened to physicians talking to my mother about noncompliant patients that did not show up to their appointments or follow up with treatment recommendations. One core task of my mother's job was to contact the patients and encourage them to come to the hospital outpatient clinic and or assist them with any social or medical barrier affecting their treatment. Most of the time my mother scheduled a home visit, especially if the patient did not have a phone or did not respond to a letter sent by the hospital.

I enjoyed home visits that allowed me to travel outside the city. Most patients lived in rural areas, which I rarely visited before. Quickly, I was educated on the impact and role of poverty in health. I thought that everybody lived like me, in a house, with running clean water and electricity. Sadly, I realized this was not the case. I visited homes where families slept in the dirt with no beds, no running water, and no electricity. This extreme poverty was totally unknown to me, but by this young age, I learned that the hospital and the physician were not aware of social and economic situation of their patients. Lacking transportation, money, and physical living environment placed their health at higher risk. Visiting their physician or following treatment instructions had lower priorities compared to their daily life struggles with subsistence.

From interactions like these, I learned two meaningful personal and professional life lessons. First, that addressing poverty and social determinants of health are fundamental to improving the health of the indigent population and addressing them has greater health impact than working only from the local biomedical oriented clinic-based care. Second, the gap between my life experiences, both personally and professionally, is wide and deep with those from my patients. I need to be mindful of these gaps to avoid bias thinking and my characterization of patient conditions and behaviors.

Advice for Professionals in the Field

- All behaviors are contextual. Understanding the context though the patient's eyes and meaning making through their stories are fundamental tasks to effectively help our patients.

- We need to be mindful of our upbringing, values, and culture as we join with our patients to be understood as they see themselves through their meaning making stories.
- There is a lot that is unknown in health care, and every piece of knowledge is tentative. We must learn to feel comfortable with not knowing and be eager to learn from our patients and others, including team members.
- Participating in an interdisciplinary, collaborative, and reflective healthcare team helps all team members become more connected to their patients as fellow humans, thereby taking the fundamental step toward developing trust and healing.
- To avoid the tendency of using mechanistic efforts to fix health problems (e.g., rigid templates, catalog of algorithms, questioners, templates for history taking) we must extend ourselves even further to the domain of the human by not only listening to our patients' stories but by being touched by them.

Practicing-What-We-Preach: Recognizing and Responding to Our Own Humanness as Healthcare Providers

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My journey into medical family therapy was more of a process than it was an event. It represented a culmination of professional and personal experiences – arguably spanning from early childhood to about halfway through graduate school – that led me to understand how the fast-paced, unpredictable, and clinically intense nature of medicine is where I am most comfortable. Some say it is because I came from a "medical family." Some say it is because I am an adrenaline junkie at-heart. Others maintain that my tendencies to be a workaholic are a perfect fit with the 80-hour work weeks of residency training. Any or all of these experiences may fuel my empathic struggles vis-à-vis students or colleagues who complain about being tired after they have only seen six or seven patients/families in a single day.

Medical practices – hospitals, clinics, trauma response teams, etc. – are usually more intense than the conventional private-practice therapy jobs for which most graduate programs train young professionals. And while some gravitate toward medicine (like I do), I have found that these care contexts will chew-you-up and spit-you-out if you are not careful. What about all of that warm-and-fuzzy "self-care" stuff that they talk about during the last two minutes of conference presentations or within the comfort and safety of practicum/supervision groups? I learned the hard way that you cannot just offer lip-service to taking care of the person who you are with 24 hours-per-day (i.e., one's self).

I had an epiphany several years ago after working "call" for a large medical system. Having been awake for almost 30 hours, I was ready to go home. It had

been a relatively "normal" shift, with some nonemergency presentations (e.g., depression, chronic pain), some urgent situations (e.g., stroke, suicide ideation), and some more heartbreaking things (e.g., a positive HIV diagnosis, a lost pregnancy, an unexpected and tragic death of a loved one). While driving home, I began thinking about how I, as a healer, was giving all of myself to my patients and their families. I was helping them to cope and/or reclaim their mental and physical health. But at the same time, my well-being was deteriorating. I was depressed. I was overweight. I was not following any of the sleep hygiene strategies that I am so good at teaching others to do. I was going to an empty house as a divorcee because I could not hold my own personal relationships together (despite being good at helping others with theirs).

We know that depression, anxiety, alcohol abuse and dependence, burnout and compassion fatigue, relationship dissolutions, and a variety of other sequelae are more common – ironically – within groups of people whose job it is to allay others' suffering. I recall pulling over on that drive home, finally falling apart in tears because I knew – or was least beginning to admit what I had already known for some time – that I was becoming a statistic. I would like to say that this was a turning-point with a "happily ever after" ending – that I immediately changed everything around with my diet, my physical activity, my relationships, and my work–life balance. This is how things would have gone in an inspiring movie or engaging self-help book. Instead, and in a similar way to my process (not event) in choosing MedFT, I began taking steps to practice what I preach. I started walking – and eventually jogging – around a nearby lake. I began going to the grocery store for food instead of various drive-throughs on my ways to-and-from work. I started seeing my own therapist. I rekindled friendships and resumed a social life. I stopped working so much (and do not think that anybody noticed). I lost 50 pounds. I met an amazing woman who I am blessed now to call my wife, confidant, teammate and friend.

My success with all of this – working hard, playing hard, balancing personal and professional pursuits – is dynamic. It has gone up and down over the years, and I have learned that, at least for me, constant vigilance to self-care is essential. I gained back (and lost again) that 50 pounds a few times before I finally figured out how to eternally keep my own self on my to-do list. I still take on too much sometimes, only to then recover and resume the ability to say "no" and set limits. Nowadays, I am more consistent with all of this than I have ever been – but I know to never take any of it for granted. Never, ever.

Professionally, my attention to self-care has translated into sensible work hours (I average about 50 hours-per-week nowadays). But my clinical and teaching efforts are more rewarding and effective than they have ever been. My "products" as an academic (e.g., publications, grants) are better in both quality and volume compared to my 80 hours-per-week days. Personally, my attention to self-care has translated to things – in terms of my own mind, my own body, and my own relationships – that are even more important. I am thereby glad for my struggles; they taught me that there is more to life than work. And my realization regarding this has made all the difference.

Advice for Professionals in the Field

- There is more to life than work. If you are not engaging in things outside of your hospital or clinic – for your own health, your friendships, your marriage, your family, etc. – you may lose all of them. And often times by working less, we accomplish more.
- Your hospital or clinic was doing fine before you joined them. They will do fine without you someday, too. Be careful about presuming that it is only you who can effectively respond to a clinical emergency, advance an educational or training sequence, or cover for a particular colleague. Learn how to say "no," and to internalize the notion that you are not as indispensable as you sometimes think you are.
- Remember the "rocks, gravel, sand" metaphor as you prioritize your day (and your life). Like filling up a jar without running out of space, you must attend to the big things first. Make sure that you – the only person who you are with 24 hours per day – are one of the rocks. This way exercising, date-nights with your partner, time with your family, etc., are not crowded-out because you "do not have time." If it is important, you have time. And there will always be time later for the less important things (gravel, sand) like getting your car's oil changed, mowing the lawn or checking Facebook.
- It is better to do 10 things well than it is to do 11 things poorly.
- If you are hurting, seek help. Healers are often reluctant to seek out other healers, but we are just as human as any of our patients. Do not be afraid to ask your physician or a trusted colleague for a referral to see a therapist. Participate in a support group, seek peer-supervision or talk with your faith mentor or advisor.
- Do not catastrophize backsliding. If (or when) you notice that you are not practicing what you preach to your own patients, students, etc., work to reclaim what you have let go. Self-care requires consistent and everyday attention.

"I Need Who?"

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Mentorship has always been a fascinating topic to me. I have experienced mentorship at different levels throughout my academic experience – from working with a guidance counselor in high school to being assigned an advisor in college that shaped the formative years of my life. There are many definitions of mentorship, but the one I have found most impactful is a mentor is someone who serves as a guide, who even though they have seen what lies ahead, is willing to walk beside you – leading but never leaving you behind on your journey. With my personal experience with informal and formal variations of mentorship, one could assume that I would

naturally continue this process into my professional life, but that has not exactly been the case.

I have always wanted to work in a health care setting. When I was exposed to health psychology as an undergraduate, I could combine my interests of health and clinical psychology in a concrete way. In graduate school, I received additional training in medical settings, specifically working in primary care and specialty pain clinics. I was also given many opportunities to teach undergraduates and graduate psychology students, which further refined my interest to work in an academic health center or medical school setting. At the time, I did not know exactly how to prepare myself for this position, but I was fortunate to have advisors throughout my graduate training who provided guidance on the steps to take to work in an academic health care setting. However, due to the intricacies of dealing with the ebbs and flows of academic life – I was not quite sure how I would navigate this new territory.

During my fellowship training, I learned about a group mentoring program which was part of a national association. Side note: I fashioned myself as a professional stalker – not what you are thinking. I was (and still am) really good at finding out information about researchers and authors whom I had a strong appreciation for their work and wanted to find a way to meet them in person – either at a future conference or, in a mentoring program. When I discovered a particular academician in medicine I very much admired who could be a potential mentor in this program, I jumped at the chance and submitted my application. I was fortunate to be matched to this individual to receive a year's worth of valuable advice and encouragement not only from the mentor but also from my peers in the mentoring group.

As the mentoring program was ending, the mentor offered to continue to mentor me – if it was something I wanted. Of course! I was ecstatic and humbled at the same time. To this day, this individual continues to mentor me through monthly phone calls filled with encouragement, honesty, and critical conversations along the way. I have even added a few more mentors along the way but this initial mentoring relationship has truly shaped my career trajectory. It helped me step out in faith and take risks, understand that the grass is not always greener on the other side, encouraged true self-care, and taught me that failure is okay and when I can learn and grow from it, it is a bonus. Having this perspective shift has helped me understand and come to enjoy the ebbs and flows of being a psychologist with multiple and sometimes conflicting roles in a medical setting.

Advice for Professionals in the Field

- If you do not have a mentor, consider getting one! You do not have to be an academician to benefit from having a mentor.
- Do not forget your peers! They can serve as great mentors too – especially on the fly. Peers may be experiencing some of the same joys and struggles that you are – shared experience can be a powerful experience.
- Mentors can serve different roles: coach, cheerleader/encourager, sponsorship, career guidance, just to name a few. Sometimes one person can fill all these roles,

but it is okay (and probably desirable) for you to have different mentors fill different roles. You may have a mentor that focuses on your role as a clinician. You may have another mentor that focuses on your role as an administrator or researcher. Having multiple mentors can be a great benefit.
- You may want to consider having a mentor who is not in your discipline. It can give you a different perspective/worldview. Is not expanding your perspective what it is really all about anyway?
- Our professional lives can be challenging. We are pulled in many different directions with competing demands. Mentorship can truly help you refocus and determine what the most important elements of your career are and then tend to those areas more often than getting lost in the weeds. How do you get started? The first step is to take the risk and ask someone that you admire. I promise – the risk is worth it.

Finding Your Place

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Collaboration was the concept that drew me to Medical Family Therapy. The idea that I could work with physicians to provide holistic care excited me about integrative healthcare. During my internship at a family medicine center, I was the only MedFT intern and was introduced to a family physician that was interested in mental health treatment. We were paired to conduct co-therapy and I was tasked with teaching the physician basic therapy skills. At a time when I should have jumped at the opportunity to partner with a physician, I instead cowered inside because all I could see were our roles in the medical system hierarchy and our differences in social status. This hierarchy is based on factors such as education level, scope of practice, prestige, and money earned. I was a young, inexperienced, unpaid Asian-American female therapist-in-training, and the physician was a confident, middle-aged Caucasian male who was knowledgeable and held degrees in many fields. He was nothing but respectful, collegial, and eager to learn, but I was filled with internalized prejudices that resulted in a lack of confidence, fear, and frustration.

As I reflect on the experience, I realize how much pressure I had put on myself to positively represent the minority groups with which I identified. I was given a position of power to teach this physician basic therapy skills, but I was plagued by my perception of being at the bottom of the hierarchy. Despite being in a learning environment where mistakes are assumed to happen, I felt as if any mistake I made would reinforce stereotypes, such as being immature, meek, or weak, that were associated with my identity groups. My fear of the self-fulfilling prophecy obstructed my sense of self, and I lost sight of all I had to offer our co-therapy team. I doubted myself and my ability to help patients. Then we met “Marisol.”

Marisol was a middle-aged Puerto Rican woman from a low socioeconomic status with numerous health issues, including a traumatic history and symptoms of major depression with hallucinations. She and I met alone for her first therapy session where she shared that she had never before sought mental health treatment. She was courageous yet hesitant, and I was hopeful that therapy would help. Marisol reported that her medications were not working, and with her trust and permission, I invited my physician co-therapist to join us. Marisol extended her trust to my colleague because she could see that I trusted him, and all future sessions were conducted as a team. This approach allowed Marisol to safely process her trauma, gain agency over her medical care, and increase awareness of the relationship between physical and mental health. In our work together, Marisol's hallucinations diminished, her ability to cope and engage social support increased, and her health issues resolved.

In our final session together, we asked Marisol if she could identify what was most helpful about our time together. She shared that she felt cared for in a way she never had in the past. She felt that we had truly seen her as a whole person and treated her as an equal. I realized that while we each brought different perspectives, social statuses, and roles, treatment was successful because we connected as humans who trusted and valued one another. We each had knowledge, care, and motivation to offer each other. Though this experience I learned that collaboration is not just a treatment approach, it is a humble posture.

Advice for Professionals in the Field

- Although the medical system can be hierarchical, therapists bring valuable skills and perspective to the treatment team. Have confidence in what you have to offer.
- Find your champions. There will be some who do not understand what a therapist does, so find those who value integrative care and are willing to advocate for you.
- Remember that you cannot do it all. You are one of many members on a team. Identify, appreciate, and rely on others' strengths.
- Take time to reflect and gain awareness of your internal biases and prejudices and how they may impact your ability to work in a system with roles often distinguished by power and status. Are your internal biases hindering you, a colleague, or a patient in some way?

Conclusion

These narratives from the field highlight several important themes when navigating the waters of the medical world. The concept of self-care and awareness of burnout was a common thread across many of the stories and advice given by these profes-

sionals. While some stressed the importance mentorship plays in advocating for self-care, others had to find their own path to establish personal/professional boundaries in their lives. The importance of being part of a team and seeking help when needed from colleagues was very beneficial for these professionals. How one enters a new setting or health care system reiterates the role that the behavioral healthcare provider (BHP) plays as a "beginning anthropologist" in this new environment.

While the need for mental health services in medicine will continue to grow in coming years, there is a looming shortage of BHPs and mental health providers in these settings (Blount & Miller, 2009; Hall et al., 2015). Graduate mental health programs and internship sites would benefit from increased curriculum and community experiences to get new professionals exposed to the world of medicine earlier in their training (Newton, Woodruff-Borden, & Stetson, 2006). Supervisors should also be mindful that first-time trainees or new professionals are likely to encounter personal issues in a medical environment that warrant ongoing attention and support.

Through this book, our hope is that clinicians can grasp the importance of how practicing in medicine impacts one's "self" in many areas, including family of origin, faith, culture, professional competencies, power status as providers, and ethical decision making. We also encourage readers to use the ideas in this book to help expand opportunities to effectively treat patients, couples, and families with emotional and physical concerns in the broader health care system. Even after several years of clinical and supervisory roles at medical sites, Jackie and Max continue to discover new areas where our 'self-of-the-therapist' work continues to arise. We invite you to keep attending to how your growth evolves not just as a professional but as a human being. After all, you can't heal effectively if you do not understand and comfort yourself.

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