Primary Care Physicians’ Experiences Treating Patients with Behavioral Health Needs

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Primary Care Physicians’ Experiences Treating Patients with Behavioral Health Needs

By Lauren E. Dennelly

2023

Submitted to the Faculty of Bryn Mawr College
in partial fulfillment of the requirements for
the Degree of Doctor of Philosophy
in the Department of Social Work and Social Research

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Abstract

The delivery of behavioral health care in primary care shapes the patient-physician relationship, which is a core area of focus for examining patient outcomes. Though early research demonstrates the benefit of integrating physical and behavioral healthcare to the patient experience and health outcomes, little research examines the relational implications of this care from the perspective of the primary care physician, including the role of physician burnout. The following study utilized a mixed methods approach to first examine the experience of burnout among primary care physicians who work with patients with behavioral health needs and then, to explore the dynamics of their relationships with these patients. Qualitative findings from semi-structured interviews along with scores on the Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI-HSS MP) were analyzed from 15 physicians working in primary care for a large hospital network. Burnout scores were used to categorize participants into one of five burnout profiles, including engaged, overextended, ineffective, disengaged and burnout. Pen portraits were created for each participant and categorized by burnout profile. Findings revealed variation in physician relationship building and behavioral health treatment capacities along the burnout continuum, with burned-out physicians reporting more constraints on their time, scope of practice, and ability to maintain work-life balance, aspects that threatened their relational philosophy of care with these patients. Implications for the role of medical social workers in supporting primary care patient-physician relationships with behavioral health patients is discussed. Keywords: behavioral health, primary care, burnout, social work, integrated care, patient-physician relationship
Dedication

For my parents

Denise Adam

and

Richard M. Dennelly
(1948-2021)
Acknowledgements

I would like to take a moment to extend a thank you to those who have shepherded me through the dissertation process and through my doctoral program at Bryn Mawr’s Graduate School of Social Work and Social Research. An incredible amount of ‘life’ has happened over that time, and I would not be where I am today without the support of the following people:

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# Table of Contents

Abstract ............................................. ii  
Dedication .......................................... iii  
Acknowledgements ................................. iv  
Table of Contents ................................ v  
List of Tables ..................................... vi  
Chapter 1: Introduction .......................... 1  
Chapter 2: Theoretical Overview .............. 8  
Chapter 3: Methodology ......................... 12  
Chapter 4: Engaged Participant Results and Pen Portraits 23  
Chapter 5: Overextended Participant Results and Pen Portraits 45  
Chapter 6: Ineffective Participant Results and Pen Portraits 58  
Chapter 7: Burnout Participant Results and Pen Portraits 72  
Chapter 8: Uncategorized Pen Portraits .......... 82  
Chapter 9: Core Themes Across Portraits ...... 89  
Chapter 10: Discussion and Implications for Research and Practice 96  
Appendices .......................................... 115  
References ......................................... 139
## List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pattern of Maslach Burnout Inventory (MBI) Subscales Across Profiles</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>Participant Practice Specialty and Identified Gender</td>
<td>23</td>
</tr>
<tr>
<td>3</td>
<td>Emotional Exhaustion (EE), Depersonalization (DEP), and Personal Accomplishment (PA) Scores for Engaged Participants</td>
<td>24</td>
</tr>
<tr>
<td>4</td>
<td>EE, DEP, and PA Scores for Overextended Participants</td>
<td>45</td>
</tr>
<tr>
<td>5</td>
<td>EE, DEP and PA Scores for Ineffective Participants</td>
<td>58</td>
</tr>
<tr>
<td>6</td>
<td>EE, DEP and PA Scores for Burnout Participants</td>
<td>72</td>
</tr>
<tr>
<td>7</td>
<td>Participant Themes by Burnout Profile</td>
<td>114</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

The first healthcare relationship people often form is with their primary care physician, the initial impressions of which can influence continued interactions with the healthcare system as a whole and thus the general health of the public. With the COVID-19 pandemic, the role of primary care in public health has become even more significant, as it remains both the first point of contact and the main source of follow up care for long neglected chronic conditions post-pandemic (Rawaf, et al., 2020). Within a value-based payor system, the patient experience, in which the quality of the patient-physician relationship is related to varying levels of patient satisfaction, is an area in which considerable resources are being allocated to improve patients’ perception of their care (Adams, et al., 2015). Though there is no unifying theory on the drivers of the patient-physician relationship, researchers have studied various components of this relationship that influence how patients experience their care, including communication (Ha, et al., 2010), empathy (Derksen, et al., 2013), trust (Chandra, et al., 2018), and concordance (Street, et al., 2008).

An exploration of these elements of the patient-physician relationship is perhaps even more salient with patients who have behavioral health needs, as they are both more vulnerable and more complex, which creates a unique patient-physician dynamic within the medical encounter. It is important to note here that though the literature frequently separates the treatment of mental health and substance abuse issues, particularly in relation to primary care practice, the
present study utilizes the term ‘behavioral health’ to refer to the treatment of both mental health and substance abuse issues within primary care patient populations. The patient-physician relationship may be impacted by behavioral health conditions because of stigma and threats to provider wellness such as the components of burnout. First, prior research suggests that stigma within healthcare interactions may play a role in service provision for this population (Knaak., et al., 2017; Van Boekel, et al., 2013). Provider attitudes about recovery, patient internalized and externalized experiences of stigma, and viewing patients as their mental health diagnoses rather than as people can strain the healthcare relationship by impeding access to care and influencing patient perception of the system as a whole (Earnshaw & Quinn, 2011; Knaak, et al., 2017). In addition, physician burnout, a significant factor in the healthcare workforce and a public health crisis impacting healthcare providers (Jha et al., 2019), impacts primary care physicians disproportionately (Shanafelt, et al., 2012), and may be a factor in working with patients with behavioral health needs in particular.

Beginning in the 1990s with Christina Maslach’s work on the development of a burnout inventory (1996) and culminating recently with the World Health Organization (WHO) designating burnout as a significant ‘occupational phenomenon’ (WHO, 2019), the emotional well-being of the professional has become a significant factor in helping professions, particularly medicine. This has resulted in shifting priorities for healthcare systems, including adding a ‘quadruple aim’ to healthcare goals that includes professional well-being (Bodenheimer & Sinky, 2014). Burnout, defined as a “psychological symptom of
emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who work with other people in some capacity” (Maslach, et al., 1996; pg. 192) is a significant contributor to physician mental health and thus the well-being of the public (Jha, et al., 2019). People with behavioral health needs often present with trauma and difficulty with interpersonal skills, placing an additional strain on the patient-physician interaction (Wampole & Bressi, 2019; Muskett, 2014; National Association of State Mental Health Directors, 2008). Presently, the specific interpersonal dynamics that influence the primary care treatment relationship with behavioral health populations remain elusive. The physician perspective, though significant in its conceptualization of relational difficulties with patients, is often overlooked, as are the elements that shape the relationship with their patients who have behavioral health needs.

It is therefore imperative to explore the experiences of primary care physicians who treat patients with behavioral health needs and develop strategies to help support them in order to help improve patient care, adherence and job satisfaction, and to mitigate burnout and sustain the primary care workforce. The shift from quantity to quality-based healthcare involves an examination of physician identity, development of new leadership skills to head team-based care teams, and a renewed focus on the patient-physician relationship as a driver of care rather than simply clinical knowledge (Nutting, et al., 2009). The existing literature points to the impact that the patient-physician relationship has on the patient experience and clinical outcomes, though we don’t yet understand enough
about the role that patients with behavioral health needs play within this relationship from the perspective of the healthcare provider. The purpose of the present mixed methods study is to understand the experiences of primary care physicians who work with patients with behavioral health needs in outpatient settings, to explore the implications of these interactions on issues of trust and collaboration, and to measure burnout as a component of the patient-physician relationship.

Recent literature suggests that 25% of health-related disability can be attributed to mental disorders (Kroenke & Unutzer, 2017). The treatment of behavioral health issues in medical settings, particularly primary care, represents a significant area of growth in research and practice in the healthcare field. People who experience depression often seek treatment in the primary care office rather than through a mental health agency (Borowsky et al., 2000), and the number of people who see their primary care physician rather than a psychiatrist for mental health care is increasing (Kroenke & Unutzer, 2017). Psychosocial and unexplained somatic symptoms consume a disproportionate amount of the primary care physician’s visit time (Curtis & Christian, 2012), and mental health conditions are often misdiagnosed or underdiagnosed, particularly in minority populations or in populations who frequently underreport symptoms (Borowsky et al., 2000). With the addition of the Patient Centered Medical Home model (PCMH) within the ACA, primary care is now required to encompass certain core tenets, including accessibility, comprehensiveness, coordination/integration, and sustained partnerships (Stange, et al., 2010). Fulfilling these requirements
inevitably means working with patients with multiple chronic conditions including behavioral health needs.

Though researchers have studied the impact of behavioral health integration in primary care on more tangible factors such as patient health outcomes and cost (Reiss-Brennan, et al. 2010; Katon, et al., 2010; Szymanski, et al., 2012; Balasubramanian, et al. 2017), there is a dearth of research that examines the impact on the patient-physician relationship, specifically eliciting the perspective of the physician. Amid the push for understanding the patient’s experience, it is important to ask physicians about their experience of the ongoing changes in healthcare and how this shapes their practice both globally and interpersonally. Few studies have examined the specific relationship dynamics between primary care physicians and patients with behavioral health needs.

Examining the relationship between primary care physicians and patients with behavioral health needs is relevant given the emotional demands of working with psychiatric patients, particularly those with complex histories of trauma (Wampole & Bressi, 2019). It is common in medical treatment for providers to view these patients as demanding and emotionally draining, rather than lacking the interpersonal skills necessary to get their needs met. Stigma, particularly for those with substance abuse issues who are often perceived by healthcare providers as violent, manipulative, and lacking motivation, can place a strain on these interactions (Van Boekel, et al., 2013). Though there is a gap in this literature regarding behavioral health populations in a primary care setting, this research
suggests that stigma can be a powerful force which shapes healthcare interactions for patients with behavioral health issues and the providers that treat them.

Further, treating patients with multiple physical conditions in addition to one or more mental health conditions in a brief visit can be overwhelming for physicians, leaving them feeling ill equipped and frustrated. Emotional exhaustion, depersonalization, and reduced personal accomplishment can lead to feeling emotionally depleted in caring for patients, adopting a harsh or judgmental attitude towards patients, and feeling a sense of negativity about one’s performance and overall job satisfaction (Maslach, et al., 1996). Physician burnout has been found to contribute to poor patient outcomes, lower patient satisfaction, and a reduction in the primary care workforce (Bodenheimer & Pham, 2010; Halbesleben & Rathert, 2008; Ratanawongsa, et al., 2008). Further, studies that examine the growing feminization of health care have found that female identifying physicians tend to treat patients with more psychosocial needs while being paid less than their male identifying colleagues (McMurray, et al., 2000), which may lead to higher levels of burnout.

Notably, a report headed by the Harvard T.H. Chan School of Public Health has reinforced the idea of physician burnout as a public health crisis, emphasizing the importance of addressing the mental health of the physician in ensuring the health and well-being of the public (Jha, et al., 2019). Systemic factors, including increasing expectations of primary care physicians, the complexities of the electronic medical record (EMR), and a significant amount of time spent on administrative tasks including documentation, all act as contributors
to provider burnout (Bodenheimer & Sinsky, 2014). Decreased autonomy, increased patient load, and the pressure to meet quality metrics also have a significant impact (Barnett, 2017). As physician burnout becomes a rising concern, it is important to examine what role treating increasing numbers of patients with behavioral health needs might play. Social workers working in primary care settings should be aware of the influence of burnout on the interpersonal dynamics between patients with behavioral health needs and primary care physicians and should be prepared to support colleagues in managing this population in order to help minimize physician burnout.
Chapter 2: Theoretical Overview

In order to further understand what shapes the patient-physician relationship with patients with behavioral health needs, we can turn to the literature on the therapeutic relationship in psychotherapy to begin building a conceptual framework. Michael Balint first began applying the concept of the therapeutic relationship in psychotherapy to doctors and their patients in the 1950s, focusing on common problems within the general practice setting. The development of case consultations, called Balint groups, continues today as part of family medicine education and assists primary care physicians in understanding different ways of managing the various problems that primary care patients bring to the medical encounter (Jones, 2011). Balint’s work was developed with the idea that many issues in general practice (i.e., primary care) present themselves as ‘neurotic illness’, for which the relationship with the general practitioner is the main ‘drug’ prescribed (Balint, 2000; Jones, 2011). Balint notes that the relationship between a general practitioner and the patient is unique from that of a specialist in that it is ongoing, allowing for further attention and development of the relational component in treating illness (Balint, 2000). The doctor-patient relationship, according to Balint, is characterized by a series of ‘offers’ from the patient and ‘responses’ from the doctor, the outcome of which determines not only diagnosis but also the level with which the patient feels heard and develops trust in the relationship (Balint, 2000). In discussing a specific case in which this exchange did not go well, Balint describes a patient whose offers of illness were rejected by the physician, thus resulting in a weakened patient-physician relationship:
What he [the patient] certainly did realize, however, was that all the doctors were at pains to convince him that there was nothing wrong with him, i.e., they were rejecting his proposition. When he came back to his doctor with the hospital report, the previous trusting, friendly attitude had been badly shaken, the model patient had turned into a disappointed, suspicious, mistrustful man (Balint, 2000; pg.23; bracketing added).

The application of the therapeutic relationship to general practice is further strengthened through an examination of Edward Bordin’s concept of the working alliance in psychotherapy. Collaboration, according to Bordin, is at the heart of the working alliance, and is the core around which the concept of the alliance is formulated (Horvath & Greenberg, 1994). A collaborative relationship engenders a sense of safety in the client’s exploration of the self; the foundation for the development of this collaboration is built on the expectations and goals developed by the therapist and the client (Horvath & Greenberg, 1994). Further, a strong working alliance, according to Bordin, is related to a goodness of fit between the demands of the work and the individual personalities of the therapist and the patient (Bordin, 1979). This work involves an agreement on the goals and tasks of the therapy, as well as bonding between the therapist and the patient (Bordin, 1979). Little research to date has applied Bordin’s concepts to the patient-physician relationship in primary care, though researchers examining the therapeutic relationship between behavioral health consultants and patients in a primary care setting note that while a strong alliance can be formed in this setting, there has not yet been a significant impact on symptom improvement (Corso, et al., 2012).
Understanding the patient-physician relationship within the medical encounter as a significant factor in furthering behavioral change and improving health is one piece of the underlying premise of current quality and reimbursement measures in healthcare today (Fan, et al., 2005). This sets the expectation that the relationship between patient and physician is the anchor to the patient experience, and ‘good’ experiences are likely to lead to better post-visit ratings, which are tied to physician performance evaluations. All of this relational and administrative pressure is likely to contribute to higher levels of stress among physicians, which can lead to burnout if not appropriately addressed and treated.

The current research aims to understand the patient-physician relationship, using Balint and Borden’s models as guides, by exploring how the components of trust and collaboration inherent in the relationship between primary care physicians and their patients is shaped in unique ways with patients with behavioral health needs. In understanding the physician experience in this way, we can further understand the implications for provider burnout and the role of social workers in assisting physicians in primary care settings with this population. The relevance of this inquiry is two-fold: first, it helps us to understand some of the indirect consequences of treating more behavioral health conditions in primary care settings on the relationships between the people who provide and receive this care. Second, collecting knowledge about physician experiences of burnout further develops our understanding of how changes in healthcare policy and practice have a trickle-down effect on care at the individual level. This, in turn, impacts issues of primary care workforce recruitment and retention as well as quality patient care and program development. I propose that the changing nature of the primary care
relationship, particularly the increasing number of patients being treated with behavioral health needs, places an increased amount of stress on the patient-physician relationship, and thus has important implications for how we view the burnout potential of primary care physicians. The present research will address the following questions from the perspective of primary care providers:

- How do primary care physicians describe the lived experience of treating patients with behavioral health needs?

- How do components of burnout, namely emotional exhaustion, depersonalization, and decreased efficacy shape the patient-physician relationship in primary care with patients who have behavioral health needs?

- How does working with patients with behavioral health needs influence trust and collaboration within the patient-physician relationship?
Chapter 3: Methodology

Design

In exploring the experiences of primary care physicians, this qualitative study is interpretivist and partially phenomenological. The investigator utilized the pen portrait method of analysis (Sheard & Marsh, 2019; Spiers & Beresford, 2016; Holloway & Jefferson, 2013) creating narrative summaries across multiple sources as a means of preserving the richness of participant experiences that is often lost when information becomes decontextualized. Participant portraits include material from semi-structured interviews and basic demographic information. Each portrait offers the most salient aspects of physician interviews derived from thematic analysis, including but not limited to the relational or behavioral strategies they use in their work with patients with behavioral health needs and the impact of their practice on their emotional health. Demographic information gathered included area of specialty (family or internal medicine) and gender.

Foundationally, the research is built on the belief that knowledge is socially constructed and cannot be separated from the meaning we derive through social interaction and experience (Cohen & Crabtree, 2006). This approach best fits the research question as it aims to understand both the experience and the context within which primary care physicians interact with patients who have behavioral health needs, while synthesizing the essence of these experiences (Creswell, 2013).
Setting

The research took place in a moderately sized Northeastern area of the United States about two hours outside of New York City. The majority of residents identify as white, though there is a growing population of people who identify as Hispanic. The average median income is about $70,000 and over a quarter of residents have a college degree. Physicians practicing in this area likely have trained all over the country, but many have completed training programs in New York, New Jersey, or Philadelphia, giving many of them a mix of experiences with both urban and suburban populations.

There were 42 primary care offices in this large health network. These sites were selected based upon their location, the number of physicians at each practice (2 or more), and the lack of direct professional relationships between physicians at these practices and the researcher. Of the 20 sites, 15 are family medicine practices and 6 are internal medicine practices. All the physicians in these practices treat patients with behavioral health needs.

Description of sample

The pool of participants includes 88 physicians drawn from across 21 sites. Quota sampling was used in order to obtain a similar number of internal and family medicine physicians. Participant recruitment was conducted until data saturation point was reached. Inclusion criteria was working as a primary care physician in either internal or family medicine with adults (18 and up) and treating patients with behavioral health needs. Exclusion criteria was those who work as medical students, certified nurse practitioners, or physician assistants, those who work exclusively with patients under 18 years of age.
those who do not treat behavioral health needs in their practice, and those physicians who have had a direct professional relationship with this researcher.

The primary investigator conducted semi-structured interviews via Zoom© or in person, approximately 45-60 minutes in length (n=15). After completion of the interview, each participant was sent the Maslach Burnout Inventory Human Services Survey for Medical Professionals (MBI-HSS MP) via email link (n=13).

**Recruitment/Screening**

The use of physician gatekeepers was essential in accessing this elite population. According to Parsons, et al., (1993), interactions with gatekeepers are significant social interactions which signal a differential level of motivation to elicit involvement than those of elite participants. Gatekeepers in the primary care context are often practice managers who facilitate monthly physician meetings in which new administrative or clinical information is reviewed and discussed or physician leaders within the practice who have administrative time built into their schedule. Engaging administrative physician gatekeepers to assist in accessing physicians as well as articulating the benefits of their participation was crucial in recruiting participants. Other recruitment strategies included presenting the research study and call for participants as part of family medicine grand rounds, sending emails to physicians who were recommended by other physicians who participated in the study, and contacting practice managers who presented the study flyer to the physicians in their practice.
**Human Subjects**

Research approval for Investigator Initiated Research at the research site was a three-step process beginning with a departmental scientific review, a review from the Network Office of Research Innovation (NORI), ending with Institutional Review Board (IRB) review. Once site IRB approval was obtained, the submission was sent to Bryn Mawr’s IRB for approval. It was found to be exempt with minimal risk to participants. Due to the necessity of having to meet the approval of two IRBs, there were considerable delays and revisions to the original protocol, including the IRB request to remove certain identifying demographic variables, including race and number of years in practice, which were part of the original protocol draft. In addition, the lack of an approved electronic informed consent process at the research site added another layer of complexity to obtaining consent and scheduling interviews. All but two interviews were conducted via Zoom®, as this was the most convenient format for participants. Consent was obtained via a signed and scanned consent form or through picking up the paper consent in person prior to the interview. A copy of the consent form can be found in Appendix E.

**Data Collection**

**Semi-structured interviews**

The primary investigator conducted 2 pilot interviews with recruited physicians in order to gain a preliminary understanding of the research problem from participants, as well as test out the interview guide and make necessary adjustments. Questions focused on three key areas: how physicians understand elements of their working relationships with these patients, including their conceptualization of trust and collaboration and the
components that influence it, the knowledge and skills physicians feel are required to treat patients with behavioral health needs, and the influence of emotional health on treating patients with behavioral health needs

Pilot interviews further developed the interview guide based upon what areas appear most salient to participants, made clear any questions that needed to be further developed or clarified, and worked out any potential issues with data collection.

**Measurement**

The Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI-HSS MP) (1996) is a 22-item questionnaire designed to assess three key areas of burnout among medical personnel: emotional exhaustion (9 items), depersonalization (5 items), and reduced personal accomplishment (8 items). Subscales are scored separately utilizing a scoring key. Each respondent will have a score for each subscale rather than one overall score. Burnout is measured via statements such as “I feel fatigued when I get up in the morning and have to face another day on the job” and “I feel burned out from my work”. Items are scored on a Likert scale ranging from 0, “never”, to 6, “everyday”. Recent research by Maslach and Leiter (2016) suggests the use of burnout profiles to classify scores on the MBI subscales as a means of identifying patterns of experience as distinguished from other types of stressful work experiences. These profiles include engaged, ineffective, overextended, disengaged, and burnout and can be scored across the pattern of existing MBI subscales. The discriminant and convergent validity and test-retest reliability of the MBI subscales have been well established and have recently been
updated to include the classification of subscales across newly created burnout profiles (Maslach & Leiter, 2016; Maslach, et al., 1996).

A license to access the online measure was obtained from the publisher to utilize the measure for the purposes of this dissertation. The online version of the survey measure was administered via Qualtrics survey software and also included the following demographic information: gender and whether working in family or internal medicine. The survey was sent to the participant’s email address after completion of the interview.

Analysis

Thematic Analysis

Analysis was ongoing throughout the interview process and was iterative as new material was collected. Transcripts were re-read and extensively examined for initial theme development. The researcher engaged in a thematic analysis of the interviews (Braun & Clarke, 2006) describing, refining, and condensing themes and identifying patterns in detail, until a sufficiently comprehensive and accurate account of participant experiences was produced. Themes were arranged visually to further examine the connections between them. Utilizing process, in vivo, descriptive, and axial coding, initial themes fell into two broad and intertwining categories: individual physician level factors, including relationship building strategies, physician emotional health in practice, physician training/knowledge base, and system level factors that often influenced and overlapped with individual level factors.
**Coding Process**

Each interview transcript was loaded into NVIVO 11, and first cycle coding was completed, generating process, descriptive, and in vivo codes. Next, within second cycle coding, codes where refined and condensed under several axial categories, creating the following core themes: professional philosophy of care, behavioral health training and experience, the need to put the patient in charge, issues of physician safety, time, emotional health management, making the job easier, combating burnout, and systemic constraints. Each core theme was inductively generated from a set of several sub-themes, outlined in detail in Chapter 8 of this dissertation.

**Survey analysis**

The primary investigator ran descriptive statistics on the sample based upon the demographic and burnout measure. The MBI-HSS MP is divided into three subscales and measures burnout, depersonalization, and a sense of personal accomplishment. Subscale scores were calculated for each participant, and a mean and standard deviation for each subscale was calculated for the sample. Then, cut off scores for each subscale were calculated. For example, someone with an overextended profile has a score high in emotional exhaustion, while someone with a disengaged profile is likely to score high in depersonalization. Maslach and colleagues utilize standardized z values to calculate profiles within the following critical boundaries: high emotional exhaustion at $z = \text{Mean} + (SD * 0.5)$; high depersonalization at $z = \text{Mean} + (SD * 1.25)$; high personal achievement at $z = \text{Mean} + (SD * 0.10)$ (Maslach, et al., 2019). Table 1 details the pattern of these subscales across burnout profiles.
Table 1

Pattern of MBI Subscales Across Burnout Profiles

<table>
<thead>
<tr>
<th>Profile</th>
<th>Emotional Exhaustion</th>
<th>Depersonalization</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaged</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Overextended</td>
<td>High</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Ineffective</td>
<td>---</td>
<td>---</td>
<td>Low</td>
</tr>
<tr>
<td>Disengaged</td>
<td>---</td>
<td>High</td>
<td>---</td>
</tr>
<tr>
<td>Burnout</td>
<td>High</td>
<td>High</td>
<td>---</td>
</tr>
</tbody>
</table>

*Note: --- indicates this scale is not pertinent to specific profile classification*

The means and standard deviations by burnout subscales for those participants who completed the survey (n=13) were as follows: Emotional exhaustion (EE) 17.3(8.3); Depersonalization (DEP) 5.46 (4.33); and Sense of Personal Accomplishment (PA) 42.84 (2.96). High emotional exhaustion was indicated by a score at or above 21.49; high depersonalization was indicated by a score at or above 10.87; and low personal accomplishment was indicated by a score at or below 43.14. Overall, the means for emotional exhaustion and depersonalization are below their respective cut off points, while a sense of personal accomplishment is slightly below. No participants fell into the disengaged category.

Pen Portraits

The structure of the pen portraits was adapted from Spiers and Beresford (2016) and was created to be reflective of the surveys and interviews. Unique to this study,
portraits were analyzed by burnout profile as well as the most salient themes from each interview, relevant quotes, and summary points. Portraits were designed as snapshots, and by their nature were not exhaustive. Lastly, the researcher conducted a within and across portrait analysis in order to discern the most relevant and descriptive characteristics of each burnout profile participant grouping.

**Rigor**

The research utilized three sources, including interview, a standardized survey measure, and demographic information regarding gender and practice specialty in order to gain a richer perspective of the phenomena. In order to aide in the creation of codes and significant themes, a detailed audit trail of field notes and memos along with de-identified interviews and emergent themes was generated and classified to include in a codebook, lending trustworthiness of researcher insights to the project. The information was gathered and classified as follows: First, memos and field notes along with selections of relevant material that pertain to specific notes were gathered and organized by theme. Second, a preliminary codebook was built using NVIVO 11 based upon selections. Third, each new interview and its subsequent notes added themes and further developed the codebook in an iterative process.

The use of memos in particular was valuable in organizing and documenting the analytic process by assisting the researcher in categorizing analytic concepts, creating summaries of categories that will assist in theme exploration, and achieving clarity and transparency in the coding process (Corbin & Strauss, 2015). Memos were organized under the following categories: themes generated from content, process/analysis, theory, and interviewer positionality as related to content. Intercoder reliability was conducted
with two independent coders of two separate transcripts that had overlapping codes. Each coder reviewed and independently coded two transcripts after data collection and initial codes had been formulated, offering feedback on further condensing codes. Intercoder agreement was calculated and found to have 94% reliability. This method was utilized based upon the complexity of the coding task in which chance agreement was considered minimal (Feng, 2014).

**Reflexivity Statement**

Admittedly, due to my experience as a clinician, there may have been some overlap in my clinical interviewing skills and my research interviewing skills, though one can lend itself to the other in important ways that have the potential to further the research rather than hinder it. For example, as a clinician, one tends to adopt a presentation of openness, non-judgement, and interest in the experiences of others, qualities that lend themselves well to building trust and rapport with research participants. In addition, though my position as both an employee working in a similar setting as well as a researcher, while complicated, can be viewed as a strength. Physicians are part of an elite group, one who may value the researcher having some basic knowledge of their experiences, work, and accomplishments, prior to interviewing (Zuckerman, 1972).

Specifically, my experience working in primary care as well as my specific knowledge regarding the difficulties of working with the population I inquired about may have lent itself to participants’ views of the validity of my expertise and genuine interest in the subject. Despite all of this, I was mindful of maintaining boundaries within the
parameters of the researcher-participant relationship rather than the relationship felt between colleagues experiencing similar situations. Lastly, I had initially anticipated my role as a younger female identifying researcher interviewing elite physicians, many of which may I had thought would be male identifying, could have had some impact on the flow of interviews. In my experience, physicians of a certain age and gender tend to fall into frequent if not predictable patterns of paternalism. I had predicted that in some cases this aspect may have subverted the power dynamic and caused the interviewee to gain control of the interview at points.
Chapter 4: Engaged Participant Results and Pen Portraits

Table 2 provides demographic variables, including gender and practice specialty. There was a total of five male identifying participants and ten female identifying participants in the study. There were no participants who identified as non-binary. Three male identifying participants practiced in family medicine, two practiced in internal medicine. Female identifying participants were evenly split between family and internal medicine with five participants in each specialty. As per the sampling strategy, a similar number of internal and family medicine participants were sampled. Due to the small sample size, the IRB associated with the academic institution did not allow the primary investigator to gather information on race or number of years in practice. For the ease of the reader, all participants were identified with a first name chosen by the researcher.

Table 2
Participant Practice Specialty and Identified Gender

<table>
<thead>
<tr>
<th>Internal Medicine</th>
<th>Family Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 3 includes the scores on the three burnout subscales for engaged participants. Participants in this category scored low on emotional exhaustion (at or below cut-off point of 21.49) and depersonalization (at or below cut-off point of 10.87),
while scoring high on their sense of personal accomplishment (at or above cut-off point of 43.14)

**Table 3**

*Emotional Exhaustion, Depersonalization, and Personal Accomplishment Score for Engaged Participants*

<table>
<thead>
<tr>
<th>Participant</th>
<th>EE</th>
<th>DEP</th>
<th>PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bob</td>
<td>16</td>
<td>3</td>
<td>45</td>
</tr>
<tr>
<td>Joe</td>
<td>14</td>
<td>2</td>
<td>48</td>
</tr>
<tr>
<td>Andrew</td>
<td>11</td>
<td>6</td>
<td>43</td>
</tr>
<tr>
<td>Thomas</td>
<td>8</td>
<td>2</td>
<td>44</td>
</tr>
<tr>
<td>Charlene</td>
<td>15</td>
<td>6</td>
<td>45</td>
</tr>
</tbody>
</table>

The following is the set of pen portraits for this engaged group.

**Bob**

Bob is a male identifying family medicine physician with both clinical and administrative responsibilities. He presents an aura of calm, as his years of experience would dictate. He demonstrates an awareness of integrated behavioral health as a model of collective practitioners rather than a single co-located behavioral health practitioner. He often references a reliance on protocol to assist in setting expectations and limits with patients, especially with patients who have identified substance use issues. He also frequently notes the importance of having time to treat behavioral health issues. He discusses his work in terms of his own professional awareness as well as his process in bringing that awareness and skill to the residents he trains and supports.
**Finding out what’s important to the patient**

Bob emphasizes the importance of understanding and aligning with a patient’s agenda for the medical visit and reassuring them that ‘they are in the driver’s seat’ when it comes to their care.

Yeah, I don’t find that to be that much of an issue because I umm, I find that I want to see what their agenda is and respond to their agenda. So, and then I think there’s also ways of sort of bringing the agenda together and uh their agenda is usually my agenda.... Yeah finding commonalities is critical. But I also like, it’s not a struggle for me, because I truly believe that they’re, that um, a phrase that I use is ‘you’re in the driver’s seat’. And I do believe that. I have a role to play, and I can inform them as best as I can, to the best of my ability, and they can use that or not.

This patient centered approach appears to be central to Bob’s philosophy of care as a family physician and is one that he returns to frequently throughout the conversation.

**Leveraging time in building relationships and understanding the constraints and importance of that time**

One of the most consistent refrains within Bob’s discussion was the importance of time in treating patients with behavioral health needs and the significant constraints on physician time in the primary care setting. This is due in part to the relative value units (RVU) based productivity and compensation structure for physicians, but also due to what appears to be a general lack of flexibility in scheduling.

Time is always an issue, not just for behavioral health issues but for any issues. And so, I try to ummm, be cognizant of that when it comes to structuring my schedule. And ummm, you know, huddling with the nurse that I work with because we generally work in dyads here. Umm. And try to look ahead to see oh, I might want to grab some time here or here, depending on the person, the complexity, and whether or not there might be an issue that I would need to discuss. That again would include behavioral health diagnoses.
In order to create an atmosphere of trust and caring between physician and patient, Bob identifies the importance of utilizing the longevity of the primary care relationship to his advantage. Because he can rely on seeing patients over time, it allows him to let the relationship unfold at a pace that the patient is comfortable with. This is especially helpful in treating patients with behavioral health needs, who may initially withhold information out of discomfort.

*And I think the, one of the benefits of being a family physician is that the expectation is that you build a relationship over time. And so, you just allow a person to, you know, tell you what they need to tell you over time.*

He articulates that employing strategies such as pre-visit charting and preparation help to leverage time within the encounter, and that seeing people over a period of time enables him to discuss more difficult topics in a more process-oriented way, which he feels tends to diffuse tensions.

**Asking permission to discuss difficult topics**

Bob notes that for him, asking permission to discuss something difficult within the encounter can be a helpful way to diffuse tensions and show respect for patient autonomy and difference of opinion. While this can arise with a variety of medical and behavioral issues, with the recent COVID-19 pandemic and misinformation about vaccines, Bob gives the following example of his utilization of this technique.

*...if I’m meeting resistance, then sort of backing up. Like a good example would be vaccination. And so this umm, you know, the patients in our community, there’s a high percentage of people who are vaccine hesitant, distrustful, and just sort of even though it’s so, or even because it’s especially so important, having a more sort of aggressive approach, or letting them know why I think it’s so important, from my understanding the data absolutely supports the need to be vaccinated, and to be vaccine specifically for COVID-19, like I know it’s not going to be helpful, it’s going to be a sort of push back.*
So, discussing you know, collaborating, having that softer approach, and then asking, you know, is it, you know would it be ok if we talked about this vaccine, or do you have any questions for me about the vaccine? And when there’s an opening then pursuing it, and when there’s not, I ask permission if we can talk about it next time. And um, that way it’s clear that I think it’s important. But it also, they don’t feel sort of, you know, pressured.

**Using body language as a relational tool**

Bob brought up a number of things that he considers when helping establish emotional safety and trust within the visit with patients who have behavioral health needs. He notes that an awareness of time and not appearing rushed, pre-charting to minimize loss of eye contact to the computer screen within the visit, and the utilization of body language that shows he is listening, i.e., turning to face the patient and making eye contact, are all useful strategies in building this sense of trust in the visit.

*Sometimes what I’ll do is when I need to type on the screen, I’ll just note it out loud. I’ll even apologize, oh I’m spending a little bit of time writing this down because this is important. Sorry I’m staring at the screen a little bit more than usual right now. But then after doing that I make a point of like doing physical movements so that it’s obvious that now we’re transitioning. I’ll move this away, I’ll move my body towards you, and you know, and I’m looking directly at you without a computer or a keyboard between us.*

**Relying on training in integrated care**

Bob describes the behavioral health training he received in his residency as involving a behavioral medicine clinic where he was able to observe and be observed, practice skills, and provide care to patients with behavioral health needs along with an embedded behavioral health provider. He notes that the need for this kind of training in behavioral medicine tends to be something that family medicine emphasizes.

*You know, family medicine I think is um, to my understanding, provides more training there, so we had our own version in residency where the behavioral medicine clinic that we had, we worked with, there was an embedded psychologist. We early on would have*
our visits with the patient’s consent, videotaped, and review that with a physician and a psychologist. Umm, focused I think on communication, among other things. We had Balint groups within our residency.

**Recognizing the limits in his skill set**

In examining aspects of physician training and knowledge base in working with patients with behavioral health needs, Bob takes an inventory of his ability to utilize behavioral interventions, identifying areas where he admits he does not have the clinical training.

...when it comes to sort of thinking about my skills, like I’m not, I don’t have those skills to do some kind of abbreviated form of focused, you know, brief type of counseling that I could follow a patient up with, you know what I mean? Like I haven’t been trained in that. Even for simple things, like you know, insomnia, here’s some sleep hygiene tips and skills you could employ and let me see you in X number of weeks and you could let me know how you employed those skills on your own. So. You know, or stress reduction techniques, or what have you.

**Utilizing on site behavioral health support and relying on the support and availability of collaborative or interdisciplinary care**

In speaking about his own emotional health in treating patients with behavioral health needs, Bob articulates the helpfulness of having a colleague, especially a behavioral health colleague, who is also working with the patient to see if there is anything being missed, and to share the challenges of complex patient care with another professional, stating “…it definitely helps overall with the care but it then it helps overall with the stress of providing the care.” Bob says that this kind of model “…shares that burden but also you just provide better care”. Of course, as he implies further, the success of interdisciplinary or collaborative care is only as good as the structural changes put in place to support it.
**Awareness of structural changes needed for integration to be successful**

Due to his combined administrative and clinical experiences, Bob seemed to have a good handle on what systemic changes needed to happen in order for integrating primary care and behavioral health care to really be successful and sustainable, most notably, highlighting that how services are reimbursed in primary care matters.

...it would be really good to have that referral more streamlined, to have the embedded behavioral health position to be structured and reimbursed in that way. So that they have more flexibility and time rather than also to be still mostly, like, I am, RVU based, and so that’s just churning patients out. So, there’s, you know, so that is um. So, at a very basic level that’s sort of the structure of how, the structure of the position, the expectations of the position, and crucially, how the position is reimbursed.

**Joe**

Joe is a male identifying family medicine physician with both clinical and administrative time. He presents himself as a down to earth and passionate practitioner that often has the emotional health and support of his colleagues on his priority list. He values a straightforward, non-judgmental, and proactive approach to problem solving and treating patients with behavioral health needs. He often articulates a willingness to ‘learn as you go’ and fine tune his skills with patients as he encounters new and different scenarios each day in practice.

**Leveraging time in building relationships**

In building trusting and supportive relationships with patients, Joe notes that conversations about mental health conditions, including diagnosis and medications, can be best approached as a discussion he has over time with a patient rather than something that is addressed all in one visit.

It’s chisel away. Ultimately, it’s just like getting people to quit smoking, it’s like getting people to get the COVID shot, or the flu shot, in a non-judgmental way. So not being like,
take your antidepressant meds or don’t even bother seeing me again. It’s like people with diabetes that don’t want to take insulin that have uncontrolled diabetes. You’re at the point where you have to use other therapies. Being persistent as well as showing the positives with it, but also being open to the fact that maybe there are negatives and talk about the negatives and either find ways to make those negatives accessible and acceptable for them or decide hey, we have to go in a different path, and offering other options.

He also notes that as his relationship with patients grows and he gets to know them over a period of time, it becomes easier to have more candid conversations about the benefits of treating mental health conditions.

But there are times when I say listen, I know you don’t want to take a medication and I know you very well, this is not you. You need to take a medication. Your thought process is impaired by this disease state and you need to give me four weeks. You need to give this a trial. I’m doing it for your own good. Just as I would never put something on you unless I felt it was for your health. If you came in with a blood pressure of 200/150 I’d tell you, you need to be on a blood pressure med.

**Reliance on protocol**

Joe emphasizes the usefulness of an existing relationship developed over time for a variety of reasons, including explaining to patients why there are certain protocols in place to handle controlled medications. He describes how sometimes these issues bring about conflict or tensions with patients in the medical encounter.

Yeah, so I mean I think being able to have that conversation, and I think if we don’t have these kinds of relationships, that person would have just left and gone elsewhere because they felt as a practice we had this poor opinion of them as a person that they were diverting their drugs or using other drugs. We had a conversation, an openness to why we have to do this, and having that, I think she probably still felt very embarrassed after that based on that from the fairly rude and mean emails she wrote back to that clinician through the portal and relayed that.

**Struggling with the concept of ‘do no harm’**

An idea that came up frequently throughout the conversation with Joe was a very palpable struggle with providing responsible care to patients that aims to ‘do no harm’, a
concept in line with the physician code of ethics. This theme was present in conversations about difficult decisions, again, surrounding the prescription of controlled medications.

And having patients, there’s a lot of clinicians in network that are just adamant, I will not write for any controlled substance. I’m a big supporter of that happening. I tell them listen, I agree with you, I don’t want to be starting benzos in inappropriate situations, but you also have to understand how a patient got here, and as part of our – what we owe to our community is if a patient comes in here on inappropriate meds, is determining how we can help them and not just saying I don’t prescribe those meds, you need to find a different doctor, because that’s also the easy way out. Not my problem, you know, I’m going to pass you off onto someone else. That’s our opportunity to make a difference in these people’s lives.

Support of collaborative or interdisciplinary care and utilizing co-located behavioral health support

The value of collaborative or interdisciplinary support was an overwhelming theme in Joe’s interview. The benefits of having this type of relationship with colleagues and office staff, in which they all worked together to create a good experience for the patient, was something Joe found helpful in building patient trust and making his job a little easier.

Having a team that’s just as supportive and having a non-judgmental atmosphere in our practice, that’s a big part of it, because it leads to a comfort level for patients to come in and not feel stigmatized to even have that communication. Because I’m coming in the room sometimes as the third or fourth person they’ve talked to that day. Every other person on this team, they fit the same dynamic and same approach that we’re going to have when I talk to that patient because I need to check the fact that I’m the clinician at the door because every single part of us is an equal part of the team. From the moment you check that person in, making eye contact with them and making sure they feel safe and secure and using the appropriate name and gender when checking them in, all that stuff goes just as far as me having the conversation. Because if we get one diverted instance of interaction prior to me walking in the room, I don’t stand a chance. I think having a team that supports and follows the same guidelines in the practice is huge.
He also discussed this type of collegiality in terms of support for ‘bad days’ and notes the following in response to discussion about a patient death.

Yeah, we in the practice absolutely talk about these things. We support each other and make sure we’re each okay every day as well because we know what each of us goes through on a regular basis and knows that the person sitting next to you probably has the same feelings. We’re very open about how we feel. Everybody has bad days, and you need to talk about those bad days.

Joe was very enthusiastic in describing his reliance on co-located behavioral health support to help provide resources to his patients and recalls a time when he was without this resource in his practice.

It’s amazing. I mean, just to be able to say – because I can look back to five years ago when we didn’t have it…and I’d sit there and be like okay, you said you want a male, okay, and you said you’re interested in this? And what zip code do you want to be in? And 15 minutes later, I would hand them some phone numbers that I had jotted down on a post-it note and be like, good luck. I don’t know if they take your insurance. Just being able to have that air traffic controller style to be able to direct those patients who can use outside of the network resources, because [the behavioral health specialist] can’t do it all…. So having that is huge. And then for those patients that we just cannot get them where they need to go in a timely matter, [the behavioral health specialist] sees them. She’s awesome. So being able to have that is the other half of the coin…

Acknowledging limited behavioral health training and utilizing personal life lessons to frame his approach to behavioral health patients

Joe reported utilizing his life experiences as a frame to help fill in the gaps in his clinical experience with treating behavioral health conditions. When asked about how much training in behavioral health he’d received in residency, he admitted that training in this area of practice was limited.

Probably none. Obviously, we saw patients, I spent a month with psych on the inpatient floor, which was basically walk around and write my notes for me. I did four weeks as an elective with [name of practice] about a week and a half of it was good, and the other was sit there while I write Adderall scripts…Being able to have those conversations is more life experiences yourself and meeting people where you are and having each patient help mold how you do it for your next patient.
**Physician autonomy and its relationship to physician wellness**

Joe was very colleague focused. This could have been a function of his administrative role or simply his orientation as a clinician. Though autonomy was not frequently referenced, it was quite salient to the impression of the interview as a whole, including the following comment about the connection between autonomy and wellness.

*Yeah, autonomy. Autonomy is good for wellness, autonomy is good for your patients, autonomy with some sort of, you know, recognition to the fact that we are owned by a hospital network. It’s autonomy with the checks and balances. Like you can’t just have autonomy and be like, I’m just going to go home and make dinner. You lost your autonomy. But being able to have autonomy and use that in a way to both benefit yourself as well as your patient population is key. Being able to have some of that flexibility back while still having the benefits of still being hospital employed, it’s a give and take, there’s definitely give and take, and you can’t shift too far in one direction. We probably are a little bit more towards that siloed lack of autonomy treadmill right now.*

**Andrew**

Andrew is a male identifying internal medicine physician with full time clinical duties. He has a marked interest in treating behavioral health issues in his practice. He acknowledges that he has more training in behavioral health than the average primary care physician and realizes that this is not the norm. He also emphasizes a personal interest in this population which makes him more apt to want to provide this treatment, noting that he keeps his clinical practice up to date by doing his own continuing education on psychiatric issues relevant to the population he treats. His individual philosophy of care can be summarized via his recognition that behavioral health is the ‘domain’ of primary care.
Recognizing the value of listening to patients with behavioral health needs

Andrew often reflects on what he can provide to his patients with behavioral health issues, feeling that a big part of his role is to listen to a patient’s story. He notes that the space to be heard is what many patients are seeking, especially those with behavioral health concerns. In recognizing this unmet need to be heard, Andrew is able to refer patients to a therapist as the best place to get their needs met.

It could be just that I’m there to listen, maybe it’s me listening. But what I’ve tried to do is get out of the role of the therapist because I could sit there and listen, people engage me – they don’t entertain me, it’s not a spectator sport, but people engage me. I like people... You want to say, why are you here to see me? But then you realize it’s for the space, the forum to share, the forum to be heard, and then I try to defer that [by saying] your time is better spent with a therapist who can put these things into action for you.

Viewing the medical and behavioral and interrelated and relying on training in integrated behavioral health

When asked his thoughts on if and how he views the treatment of medical and behavioral conditions as interconnected, Andrew describes a keen sense of the interplay of these issues.

Definitely...there are some patients where that becomes apparent quickly and some where it is not apparent quickly. So, I think yeah, the somatic stuff, gastrointestinal concerns, headaches, chest pain palpitations...This doesn’t frustrate me. This isn’t like a part of primary care that I don’t enjoy. It’s something that I think is the domain of primary care; that’s my opinion.

This philosophy of care appears to be a combination of Andrew’s personal interest in the population that he is treating, but also a product of his extensive training in addressing behavioral health needs in a primary care setting.

... I’ll share with you just maybe my bias which is I kind of trained in a setting where we had integrated psychiatry, internal medicine, and primary care, so I understand the relationship of in-office counselors, social workers, and actually a psychiatrist. I trained where we had a psychiatrist in the clinic and every Friday, she had office hours and I’d
go in and talk to her about our cases. She would round with us on rounds, inpatient, and so it was very cross – a lot of cross-pollination, very collaborative. Yeah, so I did residency in [residency program name], which has – if you know much about [program name], they have a very robust research and clinical psychiatric enterprise at [psych affiliate]. So that is where I trained. I trained in the primary care, internal medicine residency, so it was our generalist track, and so as opposed to most internal medicine, where it’s hospital based, I had probably a 50/50 mix between ambulatory and inpatient care, so a lot more outpatient medicine. I also was – I had additional training afterwards. I was a chief medical resident, and we do a lot of kind of crisis management there. I did a women’s health rotation, which was lot of trauma-informed care.

**Acknowledging the lack of access to psychiatry or other behavioral health support and the general frustrations of providing care to this population**

When discussing strains in the relationship with his patients with behavioral health needs, the lack of access to psychiatry is an aspect of treating this population that Andrew finds frustrating.

So for most of my folks, it’s getting them established with a therapist or counselor, and then also issues with having access to psychiatry for either medication management or individual therapy...I think the strain is a shared frustration in access to services...The other thing I think – that’s one shared frustration, the other is kind of the shared frustration of getting in to see a psychiatrist...No, I’m not kidding, I think out of maybe a hundred referrals, I think I’ve had maybe two that have resulted in appropriate contact and treatment.

In order to better meet the medication needs of his patients with behavioral health concerns and help fill the gap left by a lack of psychiatric care, Andrew articulates the value he places on his own continuing education in psychiatric medication management.

And the other – just the aside is also because I don’t feel resourced, I feel like it’s a thing I still read about. I always know that I can get a cardiologist in a second, but I know we don’t have a good dermatology network and I can’t get anybody into psych, so those are the books that I buy, those are the courses that I go to. It’s either derm for primary care or psychiatric med management for primary care are the books that I’m reading. So, it’s the area where continuing education is still a priority because I don’t feel resourced.

Additionally, Andrew acknowledges that there are inherent frustrations in treating patients with behavioral health needs who are not only unlikely to receive services in the
community due to access, but who are also resistant to acknowledging the need for these services, leaving him with few treatment options:

I have another patient who has been in the practice forever and is really resistant to get care, behavioral health care. She has lots of advanced medical conditions, including metastatic cancer, and is paranoid about anybody coming in to help her, the government is going to take her house and take her money and her family won’t support her. And these are true to varying levels, right, the family support is not there, I don’t think anybody is going to take her house, but certainly if she were to be needing to transition to a higher level of care, resources could be stripped from her. So that’s frustrating because it’s somebody who will talk at me for 40 minutes and I feel as though I don’t make a lot of change in her treatment plan. Something is not working for you. Again, I’m an allopathic trained doc and so medicines are my tool and medications are my currency. I can’t do surgery on your brain, I can’t hypnotize you, so this is my framework, my bias, but it is sometimes frustrating.

**Acknowledging rewards in treating patients with behavioral health needs**

Andrew was able to acknowledge significant rewards in treating this population, including being able to see visible change in his patients and forming a ‘partnership’ with them to help produce that change.

Well, I like it all. Again, my bias is that this is stuff that I like to do, and I think it’s important. You know, improvement of symptoms is great. I had a handful of patients just this afternoon who we started on new meds and a young woman whose mother said oh my gosh, I’ve never seen her this good, whatever that means, you know, functional. Another patient that had been doing well but is now doing better. A lot of this is the partnership, and again, even though my time here has not been decades, you kind of see things, oh, things were not good, or now they’re a lot better. I think patients do feel like there’s a relationship and I think that they do feel – something that’s tangible, right? No one’s ever going to come and be like, oh, thanks, my blood pressure has been perfect for the year. You know because you’re not going to feel it. But, oh, I’ve been feeling a lot better, or I’ve been able to make some of these changes. I think that’s what nice.

**Thomas**

Thomas is a male identifying internal medicine physician with full time clinical and residency training responsibilities. He places a strong emphasis on really ‘knowing’
patients, their stories, and what motivates their behavior. He emphasizes that time, in the form of continuity, is a central aspect of building the relationship. He is also specific in noting that the colleagues he currently works with have a true passion for the population they are working with, which makes the work more rewarding. He has considerable training in integration from his residency and previous program experiences and notes his philosophy of care centers around the importance of building a therapeutic relationship with the patient.

**Supporting patient autonomy and building rapport**

One aspect of relationship building Thomas mentions is the importance of supporting the patient’s autonomy. By addressing patient needs in a non-confrontational, and curious way, Thomas describes how he utilizes this principle in his interactions.

Well, I think you have to decide whether that matters or not, right? I believe we have to respect the patient’s autonomy, that’s a prime principle of taking care of a patient. So, they say they’re taking their medications, but their blood pressure is always high, or their diabetes is uncontrolled, what sometimes I’ll do is call their pharmacy and see what their history of filling their prescriptions is. Sometimes that brings to light that no, they haven’t had any of their medicines for six, nine months sometimes. And so, then we can address that in a non-confrontational way. Is there some problem with your medications or obtaining them? Are you going somewhere else to get them?

The concept of patient autonomy also arises when discussing how Thomas deals with any conflict or tension within the interaction.

*We have to diffuse it before you move on because you won’t get anywhere unless you do. You know, again, I think it’s patient autonomy. If the patient just doesn’t want to do something or talk about something, then okay. I’m always understanding and respectful of them.*

In terms of rapport building, one of Thomas’s central themes in his philosophy of care is the need to allow patient narratives to unfold in an un hurried and open fashion.
within the encounter. This allows him to be attuned to the importance of the relational process in treating patients with behavioral health needs in a medical setting and presents as a core piece of his professional self.

So, I think that’s one of the most important ways to build rapport, is to give the patient space to tell their story. They sometimes have a narrative to share with the doctor that they’ve rehearsed in their minds, loosely perhaps, but they come with a coherent account of whatever brings them there, oftentimes they do, and they just need a little bit of encouragement and some open-ended questions to let them spill the beans, and then you can go from there. It’s a very dynamic thing, you know, it’s a complex and dynamic process to interview – to successfully interview a patient in a medical setting.

Making an effort to maintain continuity of care with patients with behavioral health needs

Thomas names one of the challenges of providing quality care to patients with behavioral health needs as an issue of continuity. Because his practice setting is a training site for primary care residents, it is often a challenge to maintain consistency in providers, which he feels is essential which this population.

The residents come for one week, five days, they have no other responsibilities outside of the primary care setting, and they can plan to see patients back at five-week intervals. And it just doesn’t happen. If they want them three months out, that’s a standard follow up, three or six months, the schedule isn’t set so they can book patients for three months out. And then things happen in between and patients, other stuff happens to them, and then they need to come in at an odd interval, not a five-week interval, and they can’t see them. So, follow up is the missing point here, and that’s big – that’s really big.

Acknowledging the limits of control with patients

Thomas shares a story that he tells the residents he trains which illustrates the importance of knowing the limits of one’s control with patients and how to develop a sense of shared responsibility with them in their care, something he admits to having to learn the hard way over the years.
So sometimes the residents have a patient that is a real boatload of trouble, alright, and has a personality disorder and is passive aggressive and borderline type personality, that sort of thing, and brings up a million things in that visit. And so, I say, have you ever seen an ox pull?... They’ll have a pallet on the ground, and they put rocks on the pallet and whoever, whichever ox can pull the most weight wins the ribbon. And if the ox can’t pull the weight, it knows right away. It’ll pull on the harness, and it doesn’t strain, it just stops, and says basically, nope, boss, I can’t do this. And it knows. It can discriminate that. I’ll tell them that: this is like the ox; you can’t pull this. You cannot pull this. You’ll never be able to pull this patient, this patient has got to do the work. Put it back in the patient – make it clear, this is the patient’s responsibility to do this, you can’t do it for them. So, the ox pull.... Knowing the limits, knowing your limits.

**Acknowledging the strengths of interpersonal collaboration with both colleagues and patients**

In line with his relational approach, Thomas talks about the importance of collaboration with colleagues and patients in treating complex conditions. Though he gives diabetes care as an example, one could easily imagine any complex diagnosis, including behavioral health diagnoses, that could benefit from team-based care.

But, you know, there’s the key principle, is that if you’re talking about any kind of behavioral change, it has to be collaborative. It’s best when the ideas come from the patient. And I think that’s the beauty of motivational interviewing, is it helps patients articulate for themselves. So, a non-prescriptive approach is helpful in some situations, but in others, a prescriptive approach is warranted. So, a complex condition like diabetes, yes, a patient has to make decisions for themselves. I tell the residents, your patient, as we all do, we spend about 6,000 hours in a waking state every year and they’re likely to spend one or two hours in the course of four appointments with you in the course of a year. So how do you affect their lives with a condition like diabetes? Well, you create a team. And we have – actually, that’s one of the beauties of our practice...

**Acknowledging the rewards of treating this population**

Thomas is full of gratitude and fulfillment as he expresses the rewards in treating patients with behavioral health needs. He articulates a lifelong personal interest in
treating this population, and again highlights the importance of spending the time to build
the relationship and understand the thought process of each patient.

...This has always been a special interest for me in my career, is treating the person and
their psychology, being aware of their psychology, their approach to things, how they
execute, how they rationalize, how they think, how they sense, how they feel, how they
emote, this has always been an important part of my relationship building. It’s important
to me to know my patients that way. So, I like to make a little room for that in every visit.
A little bit can go a long, long way. When I see Jackie, I say, how’s Louis doing? Okay.
So that little bit carries a lot of – that builds a relationship. So, finding out a little
something about them: what’s their fingerprint in life and what’s it look like? So, I don’t
feel strained treating uncomplicated depression, anxiety, and sleep disorders, those are
things I enjoy working with patients in that realm. And then every now and then, there’s a
really nice breakthrough. I like being able to do something for them that they haven’t
been able to get somewhere else.

Charlene

Charlene is a female identifying internal medicine physician with both clinical
and administrative duties. Bubbly and engaged, she frequently mentions throughout the
interview how much she loves working with patients with behavioral health needs. She
states that this is in part due to her early experiences working in the mental health field
before applying to medical school, initially thinking she would like to be a child
psychiatrist. She relies heavily on developing scripts for her interactions with patients
with behavioral health needs and emphasizes throughout the interview the significant
rewards in working with this population. She presents as feeling-focused in her
descriptions of her encounters with patients.

Developing strategies or scripts that help build rapport and create a sense of emotional
safety

Charlene highlights the need to listen to the patient’s story with a sense of
openness and non-judgement. The utilization of scripting, or a pre-planned way of
addressing certain topics with patients, helps her to discuss sensitive topics such as the need for psychiatric medication and treatment.

And so, I always start the conversation with them that, you know, it’s a sensitive relationship that you have with your primary care doctor – and I say this for everybody – and this needs to be a good fit for you. I’m going to ask you in the next 30 minutes to tell you things that you haven’t told your best friends and your closest family members and it’s important for me to understand those things because it enables me to take care of you. And I tell them, I will never judge you for anything you ever say. And so, the way that I approach it is I always ask about anxiety and depression, and I tell them I’m aggressive in treating this. Now, that doesn’t mean I’m going to give you medicine; there are many different ways we can treat it, starting from therapy going all the way up to medications and we have many different classes of medications. But I tell them I’m aggressive in treating this because this affects you on a daily basis the same way as if you had high blood pressure and diabetes, if not more. And I tell them, I would not be a good physician and would not be able to feel like I was doing an adequate job of taking care of you if you didn’t feel emotionally healthy too.

Charlene describes her need to understand patients and their issues, again with non-judgement, and articulates her attention to body language as well as her ability to maintain empathy for patients who are disclosing sensitive issues that they may not have told anyone else.

You know, I think body language is very important. I sit fairly close to my patients without trying to make them feel uncomfortable. And letting them know exactly what I said before, that, you know, I know this is really hard to talk about, but I appreciate your honesty and it enables me to take the best care of you, not only physically, right, if it was something that was physical abuse or sexual abuse, but emotional abuse too, and that impacts their relationships moving forward. And I think as their physician, it’s super important for me to understand all that. And at the end of the visit I always say, is there anything else? I take a fairly extensive social history, and at the end, I say, is there anything else you feel like I should know about you? And I try to give them that opportunity. But I certainly, I mean, I’ve seen patients who are victims of human trafficking, prostitution, nothing surprises me. And I tell them, I’ll never judge you, and I think that’s just an important thing to let them know. But, having said that, patients who have faced such a trauma, if they’re not willing to open up, especially the first or second visit, I’m totally fine with that.
**Awareness of the need to protect clinician safety in the encounter**

In discussing what makes her feel safe in the room with her patients, Charlene draws from her extensive experience working with volatile populations, including a brief time working as a physician in a prison.

*So, my most important thing was recognizing that I stay safe at all times. And I think just little things, and I try to teach my students this too, you think it’s not going to happen and hopefully it never does, but always put yourself between – never let a patient come between you and the door. Never turn your back on a patient. Always, if you feel like you need support, get help. Bring in a chaperone if something is telling you something is wrong here. And I would say the only time I felt uncomfortable working in the network is I had a patient, I speak some Spanish too, so I get a lot of Spanish-speaking patients, and he was in his 20s and he came in for just a physical and he had no complaints. That’s always a weird thing to me because that’s uncommon. And when I went to examine him, he had a gun tucked into the waistband of his sweatpants. And I was like, oh shit…. And so I waited until he left and I was like, listen, to my office staff, we need to make sure that never happens again, and I had to call [risk management] and all this stuff. I think that was – I was like okay, just get in and get out. And you never know somebody’s intention. So, it struck me as odd. But thankfully, that was really one of the only times I felt uncomfortable. And I always err on the side of bringing somebody into the room with me.*

**Feelings related to difficult encounters with patients with behavioral health needs**

Charlene is very open about her emotional state in difficult situations with patients, particularly in situations where she feels that she has done everything she can for the patient and things are not going the way she planned, or the patient ends up switching providers.

*Now, for me, personally, as a provider, I think my hardest – the hardest time that I have dealing with this population is that I pour my heart and soul into this population in particular because I’m very sensitive to their needs. And I feel like then, if they get annoyed about something or treatment is not working and they get frustrated and they then start threatening, I get upset when they move to another provider. I’m like, you know, I just spent all this time…Sometimes it’s never enough, and I have to remind myself of that, just like everything, but this is a population that I really tend to care a lot about, more so than my average patient. I care about all of them, but you know, this population really has me. You guys think you’re going to have somebody who is going to have this discussion in-depth with you, really? In a 20-minute conversation? Good luck. So, that, to me, is the hardest thing. And I know other providers do that, but I feel like after you’ve*
worked so hard to establish that relationship and they go somewhere else, it stings a little bit.

She also describes a sense of helplessness in treating patients with more complex psychiatric needs as it is exceedingly difficult to get them into psychiatric treatment:

*I wish I could know more about, you know, treatment of bipolar and schizophrenia because that’s where I don’t feel comfortable, and I actually don’t do it. Those are the patients who need the most help and then when I can’t them into psychiatry, I feel like, what am I doing? I can’t do anything for them. Now, do I think I should be doing that? Probably not, but because the resources aren’t there for them, I feel like my hands are tied.*

**Diversifying her professional skillset as a strategy to combat burnout**

Charlene mentioned as a way to care for herself emotionally in her career was her attention to diversifying her professional skillset beyond clinical work with patients. She has this to say about the importance of diversification:

*...but I think I really realize the importance of diversification. I will not do more clinical. Right now I’m a 0.5 clinical and I actually give one of those – 0.1 to the virtual provider program where we work remotely for transition of care visits and stuff and COVID work…. But I think it’s really important to diversify. Because if I had to do this day in and day out, I, number one, wouldn’t be very good at it, probably. And number two, I wouldn’t be able to do it for very long. And I think that’s something, when I teach students, you know what, don’t just say you want to do it, do it. Because these opportunities are not going to come available unless you find them and you’re aggressive and you do a good job at them because 90% of the physicians within our network are just going to see patients for the rest of their lives and burn out and that’s gonna be it. So, I think by kind of transitioning into more administrative or virtual work or whatever it may be, but in particular, administrative, you’re able to affect change on a global scale versus the one patient here or the one patient there. You can affect thousands of patients by policy change. And to me, that gives me new energy when I think about my career.*

**Acknowledging the rewards of treating patients with behavioral health needs**

Charlene is filled with stories about the rewards of her work with this population. She maintains a focus on the success stories as well as the difficult encounters and
emphasizes the importance of maintaining a strengths-based perspective with patients that stays focused on the positive things they do to improve their mental health.

*And then I think the most rewarding thing is just that. I have patients on the flipside that I worked so hard with, and they come back, like doctor – like earlier today, that medicine gave me my life back. And that’s the goal. That’s, like, somebody having a fasting sugar of 102 and they’re diabetic. It’s the same concept. And it’s awesome. It’s a great feeling because not only did you listen to them when they came to you in a very vulnerable state, but you were able to really impact their life and hopefully all of their subsequent relationships moving forward...The other patient I had, this was at the height of the pandemic, and she was in her shower, she had no underlying mental illness, she had just lost her job and had started, in the weeks before, started thinking about hurting herself, and she was in the shower and thought it would be a good idea to hang herself on her shower rod. Before she did it, she called 911 and they brought her to [name of facility]. And I remember, she came to my office the next day, and I was like, do you realize you saved your own life? This is just so remarkable that you intervened and did that. And, you know, I was so incredibly proud of her. I didn’t even know her. And I think that as a provider, you really need to tell your patients when you’re proud of them. Like, wow, you stopped using heroin; that’s incredible. That deserves so much recognition for something – I can’t even imagine how hard that is. I feel like it goes unspoken, they’re embarrassed they were doing it in the first place. Like, this is your disease. It chose you; you didn’t necessarily choose it, but you chose to get out of it. And so, she came to me, I started her on an antidepressant, and she was remarkable ever since then. And she comes in and she said, you gave me my life back. I’m like, not at all, you did all the hard work. But it can be extremely rewarding.*
Chapter 5: Overextended Participant Results and Pen Portraits

Table 4 includes the scores on the three burnout subscales for overextended participants. Participants in this category scored high on emotional exhaustion (cut-off score at or above 21.49). Two participants in this group were at the ‘borderline’ of becoming overextended, defined by the researcher as being only 1-2 points away from full categorization.

Table 4

*Emotional Exhaustion, Depersonalization, and Personal Accomplishment Score for Overextended Participants*

<table>
<thead>
<tr>
<th>Participant</th>
<th>EE</th>
<th>DEP</th>
<th>PA</th>
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</thead>
<tbody>
<tr>
<td>Toby</td>
<td>34</td>
<td>6</td>
<td>41</td>
</tr>
<tr>
<td>Zaira *</td>
<td>19</td>
<td>6</td>
<td>46</td>
</tr>
<tr>
<td>Sandra*</td>
<td>20</td>
<td>2</td>
<td>45</td>
</tr>
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*Note: * indicates borderline overextended

The following is the set of pen portraits for this overextended group.

**Toby**

Toby is a male identifying family physician with both clinical and administrative responsibilities. He admits to juggling multiple job responsibilities, which causes him to be aware of the necessity of utilizing his time with patients efficiently without shortchanging them of an empathic approach. He talks openly about the challenges of managing difficult feelings that may come up as a result of a patient interaction and names some strategies he utilizes to deal with these situations. He frequently discusses
the necessity of a strong support team and collaborative work in effectively treating patients with behavioral health needs, a population that he enjoys working with.

**Acknowledging the constraints and importance of time and leveraging time in building relationships**

One of the most poignant things in the conversation with Toby is his grappling with the reality of not having enough time for his patients. This appears to plague him, and he admits to worrying that patients can sense his divided attention, despite his best efforts to be present in the encounter with them.

...And, you know, the other thing that’s a little bit sad is it depends on how much time we’ve taken to date. So if somebody – if we’re sort of towards the end of time and I feel like there’s something else that’s out there, sometimes I won’t go into it, you know, I’ll just try to do a closer follow-up or potentially, you know, engage another resource in the practice or whatever, so our enabling services or behavioral health services...I find it hard sometimes to fit it, you know, as well as I would like. So, you know, I have learned many of the skills of motivational interviewing and a lot of that kind of stuff, and you know, sometimes I feel like, you know, we’re pulled in so many different directions, especially with my more complicated medical patients, some of them I really want to do that better than I do, but I have to refill their five medicines and check in about how all of those are doing and check their care gaps and all of those things, it’s just really hard to figure out how to make it all fit.

Toby also notes that when he does have the opportunity to work with patients over a number of years, this makes his ability to work with their behavioral health needs easier, as he can utilize his previous knowledge of their baseline functioning to determine when their mental health might be in jeopardy.

...I try to kind of have a gestalt of the relationship, so, you know, it depends on is this my first time meeting somebody and it seems like they’ve had to really kind of marshal their resources to even come in, you know, and disclose as much as they have, versus, you know, some families that I’ve taken care of for ten or more years...Yeah, no, I think it’s a big difference and...you know, the patients that I’ve had that I’ve had for that long have actually followed me from another practice...So most of them, I know them pretty well and they’ve came because they’ve appreciated the relationship as well. So that makes, I think, a big difference in terms of that piece as well, right? You know, just I kind of – I
mean, I don’t know, I guess knowing that it’s not just a relationship that I value but they do too, I feel a little bit more at license to take that, you know, to kind of leverage the relationship to say, I don’t know, I’ve known you a long time and something isn’t fitting here, and those sorts of things. But for newer patients, I think it is – it’s definitely harder.

Relying on training in integrated behavioral health and utilizing brief therapeutic techniques in the medical encounter

Toby states one of the benefits of having trained with different behavioral health and medicine providers over the years, as well as training residents, is an awareness of brief therapeutic techniques that he can utilize in his encounters with patients and the opportunity to grow his skillset in this area.

Yeah, I guess I’ve been sort of fortunate that I’ve been able to continue to grow. So, in my residency, I would say we had a full-time integrated behavioralist in our office who was also a faculty member and so that was super helpful, and the family practice psych residency was big, so those things kind of helped. But then, you know, my position, I was in a faculty position right out of residency and one of my colleagues was a behaviorist, so again, I got to learn a lot from her. And then coming here and, you know, having the experience of, like, kind of co-leading, so I’ve been able to continue to grow in that. And still, we have several behaviorists, and we work together, research and teaching and everything, so I mean, I just keep learning more every year in terms of new skills, different ways to ask a question, just the little things that I think really can be transformative. My residency I think was pretty good and I’ve been fortunate to be able to continue to have those experiences.

Further, he names one specific therapeutic technique he utilizes regularly with patients who present with behavioral health needs.

I use BATHE quite a bit in terms of – as a brief technique for support for patients. So, you know, that often helps in terms of just making sure that I’m understanding some of the basics about their problem without them going into the two-hour long spiel about it. And then also to feel some empathy and support...BATHE, it’s a brief kind of counseling technique – it’s an acronym for what’s the background, sort of a little bit about what’s going on, how is that affecting you, what troubles you the most about it, how are you handling it, and then the E is for empathy.
Managing difficult feelings and the use of compartmentalization

Toby is open about his struggles in managing difficult feelings that come up for him during and after a challenging patient encounter. He details how he sets limits and manages conflict with his patients and the feelings that often come up for him as a result.

Yeah, and I think that I try to be really compassionate in doing it, right? So, to try to make it clear that I understand, you know, that we’re having this misalignment in this moment and it’s not, like, I’m not ignoring them, and I have to have – this is something that I have a priority that I have to pay attention to as well. And so, I’m really not great at – I guess I don’t want to say conflict. I’m not great at fighting. Anger is not someplace that I’m comfortable and so I really try to – I will go to some fairly extreme lengths to avoid getting myself angry and having patients get angry with me. I have definitely figured out a lot about the situations that trigger different responses from me. So, you know, I use that sometimes in my diagnostic criteria: I just left this room and I felt so anxious. He doesn’t have an anxiety disorder that’s diagnosed but there’s something there that I didn’t get to today, and that kind of thing.

After he identifies that he is having a certain emotion as a reaction to a patient encounter, Toby works on compartmentalizing the emotion in the moment to proceed through the rest of his day, and then addresses the feeling later when he has had more time to reflect. This seems to help him improve his practice by deriving relevant lessons that he can utilize to do better.

... I recognized that I was feeling that way, recognized that I needed to – what I needed to be doing in terms of my personal obligations, so I compartmentalized that, you know, you get really good at that...I was able to compartmentalize to get through that evening and then, you know, kind of over the next couple of days unpack it and kind of look back and kind of say okay, what are the things that I wish I had done differently? And so then, you know, then the following week as I was going into labor and delivery, I’m like okay, I had distilled it down to two points, two running points. I was like okay, I reminded myself of what those were. I mean, it had nothing to do with those two learning points, I just had a very good day the following week. But I have come back to those two learning points since then, so I try to keep remembering. So, I try to learn from the bad days and just keep plugging on.
**Recognizing the support of collaborative or interdisciplinary care**

Throughout the course of the conversation, Toby discussed the importance of having the support of a team to treat patients with behavioral health needs more effectively.

_In terms of the practices, I think it’s just a huge help to have people to refer to. I think many of my patients don’t trust those other places and so being able to have a warm hand-off to an embedded counselor in my practice and then to, you know, maybe that’s enough. And if not, to say I really trust this person and I trust them to tell you if they don’t have the resources to treat you but to get you to a place that will be better, and by the way, if it doesn’t work out, they’ll still be here, and we can come back to it. I feel like that is a tremendous help._

He goes on further to describe the feeling of connection he experiences co-treating patients with a behavioral health provider and the satisfaction of knowing patients are getting what they need as a result.

_And yeah, so when I lack that, I feel it more as an absence than I do a presence when it’s integrated because when it’s integrated and then I see our behavioralist in the practice and as we’re walking by, oh thanks so much for the referral for so and so! Yeah, we connected, and this is what we’re going to do. That just really makes me feel like we’re doing what we need to support the patient. And again, sometimes I hear something – oh, did you know? This person told me this. Make sure you check out my note. And sometimes it can be some really important information in terms of their medical history that I otherwise wouldn’t have, or a history of a trauma or something that’s going to shift the way that I’m word choices with them and that kind of stuff. I find that to be very helpful._

**Rewards of treating this population**

Toby is cognizant of the rewards that drive him to keep doing this work and highlights the importance of being a listening presence for patients and the value in hearing their gratitude.

_**I think that oftentimes, especially patients with depression and anxiety – well, actually, I mean, I think that many patients overall are accustomed to not being heard and seen, you**_
know? And so I really feel rewarded when somebody, you know, there may have been tears, it may have been a difficult visit, it may have been draining for me as well, but when they say – when I hear, thank you, you listened, and I feel like sometimes I hear, nobody has listened to me this way before and things like that, that definitely fuels me to do it again even when it’s hard for me.

He also notes one of the rewards in working with this population is that it’s consistent with a philosophy of care that supports the integration of counseling and medicine, two disciplines that he views as connected.

Intellectually, it’s nice to be able to try out both the counselor side as well as the medical side. [With this patient] I got to a deep dive into the medications and the techniques we can go over for sleep therapy. Because she’s already been on several other therapies, we don’t have to start from scratch. So, it was kind of rewarding.

Zaira

Zaira is a female identifying family medicine physician with full time clinical duties. She exudes a nervous enthusiasm for her work and describes herself as emotionally invested in her patients. Her emphasis on an innate or natural skill set as well as maintaining honesty in her interactions with patients who have behavioral health needs is a consistent theme throughout our conversation. She identifies multiple challenges in her work as a family physician, including managing patient expectations that are at times unrealistic, and managing her own emotions in response to these expectations. In meeting these challenges, she continuously falls back on open and honest communication, as well as an ability to garner support from office staff both within and outside of the patient encounter.
Personifying illness as a relational strategy and using collaborative language

In describing some of the scripting she utilizes with patients who have behavioral health needs, Zaira demonstrates a technique that therapists often use, in which illness is personified and viewed as separate from patients themselves.

You know I tell them all the time ‘Anxiety and depression are the biggest liars in the world. They tell you that there’s no use in complaining because you’re just weak, and everyone else goes through the same stuff, and you just can’t handle it, so don’t ask for help’. And I tell them that that’s a lie.

When discussing with patients when a particular treatment isn’t working, she utilizes collaborative language by saying ‘I’m super frustrated this isn’t working for us’. This indicates to patients that she is aligned with the goal of helping them to get better, and that this is a mutual goal that she also has a vested interest in helping patients reach.

Valuing honesty in meeting the patient’s needs

Zaira frequently mentions the importance of honesty in working with patients with behavioral health needs, particularly when discussing starting a new medication.

I’m really open with my patients, about, you know, I like this medication for this reason, I’ve had really good results with this medication. I, you know, I tell people, you know, if someone’s really hesitant, particularly for kids, ummm, I will like, be very open and honest with them, ‘I wouldn’t prescribe this if I was concerned about it’ Or sometimes I’ll even say ‘My little sister has anxiety and when she came to me asking me what she should do, I recommended this medication’. Like, I’m very honest with them, my baby sister, who I’d protect for the world, like it’s my job, if I’m giving her this medication, it’s totally safe. Like you know if it’s like their hesitant to start medication because of a family member being anti-mental health, I’ll say ‘I want you to think about that you’re an adult and we can take care of ourselves at this point, so what’s more important to you? Like you came to me concerned that your mental health is struggling. You were concerned enough to come to me. Is Dad’s opinion really that important in this scenario?

She also frames this in terms of ‘being human’ with her patients, which she describes as showing them her human side, which reminds them that she is not a machine.
churning out prescriptions but rather a person who is has concerned about their health as they are.

You know, I don’t have any shame about being human with my patients. And I think that helps a lot. Because like sometimes when you just let a little crap fly, like someone’s like, you know, like ‘I feel like shit’ and I’m like ‘Yeah, it sucks, I’m really sorry’. Being human with them really helps with the de-escalation because you’re showing them that you can get frustrated too. You’re not just this machine that’s gonna fix them.

Reliance on natural skills and personal use of self

Zaira talks about how her experiences growing up in a big family have shaped her personal use of self as a physician. She notes that she has developed good people skills ‘naturally’ as a product of her upbringing. She describes how she utilizes these skills in practice.

I’m really, I’m very aware of how people feel in the room. Someone could look totally calm, and I can tell that they’re like ready to blow up in my face. I’ve always been like that. It’s been really beneficial in medicine because the patient who’s about to have a complete psychotic breakdown might look totally calm. I just think this is who I am. I’m the oldest of three kids with a very emotional and passionate family. So, I think I’ve learned to deescalate from family stuff over the years.

Managing patient expectations, evaluation of visit, and managing conflict

Zaira was open about her struggle to manage the expectations of her patients. She notes that often when a patient does not have a good experience with the office, or if she has had to set an appropriate limit with them in some way, the outcome ends up being a poor evaluation of her as a clinician.

Every once in a while, you get a patient who gets pissed off. And then you see it on the survey. Because you know those who fill out the surveys are the ones who are really really mad…You get that provider scorecard once a month.....it makes me crazy....Yeah, so the provider score card is something that, I don’t know who does it, it’s something, it compares you to national scores and network scores. But it’s based off of what the patients write on their survey that they do when they leave. So, I will get comments that,
you know, my score looks bad because the day they came, we had a bunch of, like, they came late, they’re not saying I came late and it took me forever to see the doctor, it just says, it took me forever to see the doctor, or the front desk staff was rude, and it makes my scores go down, so this is very frustrating for me. And then, every once in a while, you get somebody who’s like, I expected to see my doctor and I didn’t see my doctor, so this doctor couldn’t do good anyway. So even right now because I’m covering for my partner who is on maternity leave, she’s been here a few years, her patients love her...I got dinged because I wasn’t her. They gave me a zero score on patient satisfaction, and I just cried about that in the car for like 30 minutes.

She states further that contending with the internet and patients’ self-diagnosis without respect to the process of medicine is also something that frustrates her about the job.

Yeah, there’s a lot of things that are expected of doctors nowadays...I think the most exhausting part of being a doctor these days though is dealing with the expectation that we’re customer service experts. You know, you’ve looked something up online, you’ve decided the mole on your arm is, I don’t know, metastatic colon cancer, and you expect me to give you these medications, and I tell you why I don’t think that’s the case, and I’m gonna do the lab work up, but I’m not gonna prescribe the medications, and they lose it....Single biggest challenge would be managing their expectations and my emotional reactions to it.... And that is so hard for me, because I’m a people pleaser.

**Issues of physician safety within the encounter**

Zaira’s heightened sense of safety when working with patients comes up frequently throughout the interview. She notes that she had an unsafe experience with a patient during her residency, and that this experience has caused her to put her own safeguards in place to ensure that she keeps herself safe during the medical visit.

*I’ve become very aware because of my residency, I had a couple patients who got very aggressive, and our spaces were much smaller than this room is, and the patient is between you and the door, and the patient is screaming at you because they are wanting some kind of medication that you’re not gonna give them, and they’re standing over you..... And he’s, he was like, 6’4, I’m 5’2, I’m sitting behind my computer...think about this bed turned the opposite way, the computer’s over there, the door’s over here. He’s on the bed and then he’s up and standing over me....So umm, my [medical assistant] and I have developed, if I’m in a room, and I flag something that’s red, like I change their patient flag to red, then she comes in...But we, if I’m in the room, and I change it to red while I’m in there, that’s a sign that I need help. But I’ve only had to use that once.
Sandra

Sandra is a female identifying internal medicine physician with full time clinical duties. She emphasizes the importance of patient autonomy and providing the patient with choice in the medical encounter. She’s acutely aware of the lack of access to behavioral health support for her patients, and she acknowledges her limited training and scope of practice regarding behavioral health issues. She is forthcoming in discussing her awareness of her own burnout potential and the burnout potential of others. She articulates the ways in which medicine has become a business, one that leaves out the human element, and is especially disheartened by the impact this has had on her fellow colleagues over the years.

Recognizing the importance of patient autonomy and presenting patients with options for treatment

A central theme in the conversation with Sandra was the importance of supporting patient autonomy. She notes that by giving people options and allowing their view of the problem to direct the visit, she gives power back to them and increases their sense of agency.

... I kind of lay everything out like a Chinese menu. And a lot of them are kind of frozen and just don’t know what to do, and by giving them options, it kind of gives them some empowerment to say okay, so I am in charge here. Giving them that power gives them leverage. I let them know each diagnosis and then I tell them, okay, what do you want to do? And I’ll put them in charge, give them all the options, and if they say, well, I want to think about it, okay, then we’re going to get back together in two weeks and see if they’re more comfortable in-office, if they want to see a therapist I get them hooked up, and a lot of times I’ll offer gene psych testing also if they’re just completely locked and don’t know what to do....I have a lot of people, they have a diagnosis of PTSD, so I’ll ask them, do you want to talk about that? Do you want to enlighten me? And if they say, no, I really don’t want to revisit it, I say okay, then we’ll just leave it on there. If they do want to revisit it, I let them kind of recap, then I ask them where they are with it, what they’re doing, and I just kind of let them direct which way we want to go with how much to disclose and treatment options. And some of them have lost control and they don’t know
how to regain it, so you have to give them that option, that power to go okay, I can do this.

Sandra is also clear on the patient having ownership over their problems, without trying to push responsibility for those problems to the physician, but rather utilize the physician for support.

I try to let them know my job is to help them and ask them, what do they need? What do they want? What are you thinking right now? Well, everyone’s against me, I just want to kill myself. Okay, that we can solve. I’ll just put it out there, what is it you’re looking for? Let’s figure this out and come up with a solution…. Because it’s not my problem; it’s theirs, and I’m here to help them.

Leveraging time in building the relationship

One thing that Sandra mentions that makes her job with behavioral health patients easier is knowing them over time. Having the longevity of a relationship helps her to be able to assess more clearly what a patient’s baseline is, set limits in terms of scope of practice, and puts the primary care clinician at a distinct advantage over a psychiatrist who may only see the patient a handful of times.

Knowing them, you know. Having that history is reassuring for them and for us. I’ll let people know very clearly what my limitations are. I’ll let them know, listen, I don’t want to hurt you, so I’ll do what I can, and then when I get to the end, I’ll let you know. But I set the rules ahead of time; I let them know…. but they also know that we know them better than the psychiatrist does. So, they’re more trusting of us.

Acknowledging the lack of access to psychiatry or other behavioral health support

Sandra had a lot to say about her frustrations with a general lack of access to behavioral health support for her patients. She notes that much of the care for this population has been placed on primary care physicians, and remarks that this does not set the physician or the patient up for success.
I think it’s – if you want to go back in the ‘80s when they emptied the mental health wards, there’s nowhere for these people to go. And it’s our responsibility, and it’s just not adequate. Some people need to be away. They do. And some people need to be cared for. And it’s not – the families can’t do it. And what are we supposed to do? They’re schizophrenic, you know, and the brother is trying to take care of them. Really? This is not going to go well. Oh, go to your family doctor. Okay, what am I going to do? And then we have the crossover with the narcotics. I mean, this is a recipe for disaster.

She also emphasizes her willingness to treat behavioral health issues in primary care provided that she is able to gain the right support from specialists whom she can access if needed when she has reached the limits of her skillset.

I’m not one – you know, some people will just say, oh, anxiety, and off they go to psychiatry. Well, that’s not going to work. No, I’ll try multiple things, I’ll do the gene psych testing. I’ll try a bunch of combinations. So, if I refer to psychiatry, I’m done. I’m done…. I will take it as far as I can go, so if I’m at the point where I’m asking for help, I really don’t like to get rejected. Because then I refer and oh, sorry, sorry, no, no. No! No, I’m referring to you, you need to take this patient, I can’t do this. You know? So I think the issue comes when I am unable to get them what they need and I’ve done everything I can…. So it’s when I’ve done everything I can, how can I get that next step? That’s where I have a problem.

Awareness of that burnout potential of self and others and the contribution of the ‘business’ of medicine

Sandra discusses her thoughts about physician burnout at length. She is acutely aware that her colleagues are struggling to manage their own wellness while balancing the demands of being a physician in the age of the electronic medical record. She notes solutions to this problem must include widespread systems change.

So I’ll preface it with this, that I am very in tune physician wellness and I’m very in tune with where we are, where we need to go, and I have my own ideas; I’ll say that. But, you know, every day is a struggle. I’m watching my colleagues struggle. Nobody really wants to do this. Nobody really wants to stay in this. And this is unsustainable and it’s untenable. Moving forward, things need to change very radically and very quickly and they’re not. And this was known when they put in the electronic medical record (EMR) edict, they knew what this was going to do to providers, and they did it anyway. And they didn’t follow up on it until now, 20 years later, and now it’s this big push and the
American Medical Association (AMA) has all these processes in place, but it’s too little, too late. I’m 55, so say I retire soon, okay, it’s going to take two people to replace me, and they’re only going to put in 20 years and be looking for something else. So, I see that as a problem. The whole system needs to be changed. I don’t see that happening and I think most people are just going to get out.

When asked if she has ever thought about leaving the field before, Sandra has this to say:

*I think about it frequently, but I don’t know what else I would do; this is what I was supposed to do. But I am pursuing my Master’s, looking for other avenues that I can finish my career. I don’t see myself making it to 70 doing this, which is a shame, I always thought I’d die with a stethoscope around my neck.*

Finally, Sandra offers a personal account of what it feels like as a physician to be offered lackluster individual solutions to a clearly pervasive and systemic problem.

...And the bloated administration, it’s just the way the business of medicine is. It just is not – there’s too many people in the boat and nobody is pulling it. So, you can’t keep asking more and more and more with no realization as to what’s really going on. And I think that’s where a lot of frustration comes from, is this disconnect, and it’s just from the business of medicine; that’s where it comes from. So, what to do about it, I don’t know, but I’m doing what I can for provider wellness and I’m on the wellness committee. They start with the solution of, well, let’s do some yoga. Don’t tell me to do yoga. Don’t tell me what to do with my free time. Make my job more tenable. You know? Or, oh, you can go to this conference, but we’re going to take continuing medical education (CME). You’re punishing me. I’ll do what I want with my CME. Maybe I want to go somewhere, and now you’ve taken that. You know what I mean? So, their intentions are good, but they’re not getting it. And I’m not just saying [name of organization], I’m talking about medicine in general. [name of organization] does an excellent job and they’re really on top of it with wellness, but this is just, you know, this is a big tiger that’s out of the cage.
Chapter 6: Ineffective Participant Results and Pen Portraits

Table 5 includes the scores on the three burnout subscales for ineffective participants. Participants in this category scored low on their sense of personal accomplishment (at or below the cut-off point of 43.14).

**Table 5**

*Emotional Exhaustion, Depersonalization, and Personal Accomplishment Score for Ineffective Participants*

<table>
<thead>
<tr>
<th>Participant</th>
<th>EE</th>
<th>DEP</th>
<th>PA</th>
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<tbody>
<tr>
<td>Teresa</td>
<td>16</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td>Sarah</td>
<td>13</td>
<td>7</td>
<td>41</td>
</tr>
<tr>
<td>Cecilia</td>
<td>4</td>
<td>1</td>
<td>42</td>
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The following is the set of pen portraits for this ineffective group.

**Teresa**

Teresa is a female identifying internal medicine physician with split administrative and clinical time. She easily identifies the benefits and challenges to balancing both her clinical and administrative functions and the emotional implications of this on herself as a practitioner. She values her ability to reflectively listen to patients, an area which she notes she has improved upon through training to help build her own self-awareness and communication skills. She is open about the challenges of her clinical and leadership work, and the difficulties of not feeling fully effective in either, despite her accomplishments.
Recognizing the value of listening reflectively

A core relational skill Teresa mentions is her use of reflective listening with her patients, and a recognition, particularly with patients who have behavioral health needs, of the desire for patients to be heard and understood by their physician.

...So what I tend to do is listen and do a lot of reflective listening techniques...a lot of it is just giving them the space to vent so they feel heard and that tends to deescalate a lot. Yes. Yes, that’s it. And you know I’ve realized, there have been a handful of times, and I stop myself from doing it now. If I ever go to tell a story about myself, I just get a sense that people check out a little bit. It’s my conscious reminder that ‘they don’t want to hear about you they want to talk about them’. So, I always, even if I try to, there’s a great example of something that I’ve experienced in my life about what they’re talking about, I hold myself back from sharing really much about myself, I really try to keep it focused on them. Asking about them, do reflective listening for them, and really kind of stay in that service mentality.

She goes on further to describe a patient situation where reflective listening helped her to de-escalate a patient and find out what needs of his were not being met.

He was all fired up about his paperwork or something that wasn’t completed for him and what they’d said on the phone, and he was using profanity and then he just showed up at the office and everybody’s like ‘We don’t know what to do, he’s really, really mad’. I brought him back and put him in a room and just listened, you know, what’s happening? You know it was the end of my workday and it ended up taking an hour just sitting and listening to him kind of vent.

Time in building relationships and working within time constraints

Teresa discusses how she is purposeful in using her knowledge of the patients’ personal history to build rapport and connect with them during their visit.

And then for people that I see over the long term, and who we have an established relationship, I always try to, you know, I have a kind of a cadence to the way I approach a visit, and the first part is always just about them, you know, and usually just checking in, how are things going, how’s the family, if I know something, you know, I’ll keep notes, like somebody’s a big camper, I’ll say ‘How have you been doing with camping lately?’. So, I’ll try to open with something personal, we’ll get to our stuff, and then I try to end with something personal, you know. And kind of follow back up with it. So, I guess those are the main ways I try to approach it.
Teresa also discusses time in terms of its constraints and the intrusive nature of patients being able to infringe upon clinician time to excess.

_Time...I wish I could give them all an hour....20 minutes for follow up, 40 minutes for a new or established patient that’s a transition of care like a hospital visit or something. For the most part 20s. There are occasionally times when I’ll try to get a two-visit block for someone if I know I really need it. But I’ll tell you the other piece that has increasingly popped up are emails...So, a lot. Like I’ll get emails from some patients multiple times a day, like every day. And the in basket is busy enough as it is, and you’re kind of like oh my gosh...Yeah, the portal. Better than a phone call that lasts a half an hour you know on your down time, emails are I guess better from that sense, you can control your time. But umm, it’s just difficult._

**Limits of her control and her skillset in treating behavioral health needs**

Teresa has an awareness of what she can and can’t accomplish as a clinician treating patients with behavioral health needs, and the futility of thinking that she can completely make up for failures of the system as a whole.

_And you know, I try not to be angry, I try to keep my emotions in check, because often times they’re just fired up about something, and most of the time it’s not something I’ve done directly. If it’s something that was outside of my control I listen and try to think of if there are ways to mitigate the situation or deescalate it in any way....I recognize I can’t do it all, which is the other flip side, right? You do what you can do and you’ve got to let the rest go._

She goes further to describe the limit that she has created in terms of treating a patient with complex behavioral health needs to remain within her scope of practice and general comfort zone as a physician.

_In the, there’s like 10-20 percent of my patients that have multiple, multiple medications. There’s one person in particular I can think of, she’s like the sickest person I’ve ever met, and her psychiatric illness is about the same complexity as her physical illness, they’re just both so complicated. And so, I feel like I wish I could have a psychiatrist with me every single time I see her, just because she’s that complicated. She’s like on 5 different psychotropics and you know, it’s just crazy. You know, you look at that situation, and it’s like ‘I can’t handle that as a primary care clinician’. I don’t even want to touch her psych_
meds. I don’t even want to titrate one of them let alone do anything different. For the most part, though, I can do two medications, dual management, psychotherapy, once it goes beyond, that’s like my rule, once it goes beyond two medications and somebody’s still symptomatic and not doing well, and we’re not progressing, that’s when I pull the flag and say we should get you in to see psych. You know so I would say that’s about 10-20 percent of the time. But it’s not, you know my panel isn’t huge, so, it doesn’t happen all the time, but it’s enough that I try to refer and get people in when they need to.

**Managing difficult feelings surrounding patient interactions**

Teresa is candid about the struggles of patient care, including feeling drained when she feels that she has nothing left to give a patient after her current interventions have not been successful.

*There’s one woman who emails as I mentioned, every day. Today I received six emails from her. It just….it’s crazy at some points, that you just kinda….I get to be, and I stop myself at times because I’m almost curt with her. And I know she doesn’t deserve it, it’s just you know, sometimes I get exhausted, you know. I get exhausted by saying the same things and realizing that it’s not making a difference. And yet, you know, she’s very kind, like she’ll always send cards over the holidays. I think she recognizes that she is a time intensive patient and that she reaches out a lot. But you know it can be very frustrating. And those are situations that are a little different. I don’t feel good every time I respond because there are times where I Respond because there are times where I’m like I’ve got nothing. I’ve got nothing I can offer to help her right now. And that’s my reality, you know. And so that I would say are times when I get frustrated, when I feel like I don’t have tools to help someone or to do something for them. And when you know, what they’re looking for is just outside what I’m capable of giving.*

Teresa goes on to describe what a bad day looks like for her, giving more detail regarding the impact of the constant balancing act of administrative and clinical responsibilities.

*So, I have had bad days. It tends to be when I’m not able to fulfill my patients’ needs and I’ll hear that feedback from them, or you know, somebody’ll say, ‘You’re just not in the office enough, I need to find somebody else’, which is completely fine, and I don’t give them any hard time for that, I actually support them in doing what they need to. But it reminds me that I’m not fulfilling their needs in the service way that I need to, and so that tends to create a bad environment for me. It creates negative feelings of inadequacy, you know?*
Using administrative time to avoid burnout and balance strain of clinical work

Despite Teresa’s feelings that sometimes she is not able to fulfill patient needs with her dual role, she does acknowledge that her leadership responsibilities help to mitigate the effects of burnout from clinical work.

...so I’m in administration for eighty percent of my week. And I think that’s helped me avoid that kind of burnout. Because I know I actually wouldn’t be able to do clinical full time. I did it for a year when my son was born because I had never been full time clinical, and I felt like I was missing something, I don’t know why, I just, I did. I feel like I need to do this for me career-wise to feel validated in being a clinician-administrator.

When asked further how she manages this balance, she has this to say:

I try to manage it as best I can. I’m on the electronic medical record every day, even though I’m not in the office. So, I try to explain to people even though I’m not here physically you can always get to me if you need anything, and so I try to kind of do the dance, so that people are able to access me even though I’m not physically present. Umm, but I also try to set expectations up front with people so they know I’m not in the office all the time so maybe we should find one of my colleagues so if you need something more acutely you know who you can partner with. So, I think I just try to communicate to navigate it as best I can. And I really do try to have a presence, kind of one foot in both canoes. But I’ll tell you it really is a balancing act, like even when I’m in the office seeing patients, I’ll be checking my phone to make sure there’s not an email that’s coming across that’s high urgency that I have to get to or manage. So, it’s always a constant kind of dual lens, you know, managing both sides. And during the day when I’m administrative I’m constantly checking my in basket to make sure I’m not missing an anticoag [anti-coagulation] encounter that I have to do for a patient INR [international normalized ratio, a measure of how long it takes blood to clot].

Sarah

Sarah is a female identifying family medicine physician in her first year of residency at the time of the interview. She presents as engaged and interested in her work, particularly in the behavioral medicine clinic portion of her program, though acknowledges her limited scope of practice despite the training she is receiving. Sarah demonstrates a good awareness of brief therapeutic techniques and relational skills to
utilize with patients and readily acknowledges the rewards and successes in the work. She does articulate the emotional strain this type of work involves and identifies the difficulty in feeling unable to help many behavioral health patients, particularly those with more complex trauma.

**Utilizing brief therapeutic techniques and relying on integrated care training**

Sarah describes her specialized training within the behavioral medicine clinic as a place where she can strengthen her clinical interviewing skills and therapeutic techniques as well as receive feedback from behavioral health clinicians.

*Essentially I operate like a family medicine doctor in the outpatient world, but we do have a half-day a week that is specifically for counseling and we have a licensed counselor and psychiatrist who are there to oversee and we start by having those sessions either recorded – not recorded but video monitored from another room or with them in the room with us until we get clearance to do it on our own and then they’re just in the other room as back-up if we need to come out and ask for help.*

She goes further to describe how she provides some basic therapeutic techniques to patients, including what patient population they work best with given her scope.

*I try to do motivational interviewing and validate their experiences and just try and reflect that what they’re experiencing, obviously it’s very tough for them and I’d like to help….so we’re not expected to handle, you know, like some of the personality disorders or if someone is in acute mania, but everyone has stress, anxiety, depression occasionally, adjustment reactions, and it’s super helpful to be able to not have to refer out and to be able to provide basic support to patients.*

Sarah describes a specific patient encounter where she anticipates being able to do more specialized work with a patient regarding her insomnia.

*…and we’ve been talking a lot about her job, and she wants to quit and find a new job and I’m trying to show her what makes a new job different, like, how will it not just become the same thing, the same situation? But then she’s also had insomnia for years*
and so she specifically came because she wanted to do cognitive-behavioral therapy for insomnìa. So, it’ll be nice to see her back in a few weeks and we get to just focus on that part. Intellectually, it’s nice to be able to try out both the counselor side as well as the medical side. I get to do a deep dive into the medications and the techniques we can go over for sleep therapy.

Acknowledging the constraints and importance of time

When asked about what kind of time she spends with her patients that have behavioral health needs, Sarah notes there are different visit lengths depending upon whether she is working in family medicine or the behavioral medicine clinic (BMC).

...It’s appointments every 20 minutes for regular days and for BMC it’s one an hour. And really, they don’t build in time in between patients for needing to collect yourself...I really appreciate having that one day a week with BMC because I can definitely tell it makes a lot of difference for the patients. Because it takes time to unpack trauma and for safety netting you don’t want to say okay, gotta go in 20 minutes.

Sarah also mentions that the support she offers to patients as part of her BMC training is time limited and due to the nature of residency programming, not always a source of continuity for the patient, but rather, a setting in which acute stressors can be addressed.

Our goal with BMC is to do six sessions or less and it’s pretty rare that we have patients come back for multiple meetings, but generally it’s a lot of anxiety, depression, and adjustment reactions or grief reactions where we’re trying to help them cope with an acute stressor. Or I’ve also done it as like a bridge to psychiatry because I know the system is overwhelmed right now and I just want to make sure someone is seeing them before then...it’s not really appropriate for long-term counseling and we can’t necessarily predict who will have an available schedule, so it’s hard even to guarantee they’ll be seen by the same person when they come back.
Recognizing poor communication between systems and the influence care experience

Sarah details situations in which she is expected to practice in somewhat of a vacuum, without information about what other psychiatric treatment the patient might have, relying solely on patient report or what limited information is in the chart. She describes a particular patient situation that leaves herself and patient having had a poor care experience.

Yeah, a lot of the psychiatry is not through [name of health network], it’s through private practices, and so we don’t have any notifications or access to those records. And so I’ve had more than one patient I see in the BMC that it turns out should be, or already are getting psychiatric services outside of [name of health network] and it wasn’t in their record or problem list. Like I had a patient who was feeling very anxious and wanted to talk about it and I saw her in BMC and figured out by the end of the session that she had paranoid schizophrenia and she was relaying these hallucinations that she was having, but she was very, very convinced they were real. And I looked at her chart and it was not listed in her chart that she had any of this....Or even I had another person who had clear depression who actually I was treating for months and started her on an SSRI and she didn’t disclose that she’d had a manic episode in her 20s and she’d been diagnosed with bipolar and I precipitated a manic episode because she didn’t want me to judge her for her diagnosis....I wouldn’t say frustrating, I would say it makes me feel really bad for the patients because I’m not really providing the care that they need, I’m making life harder for them, and especially when it comes to trauma. Nobody wants to have to share that more than once.

Feeling unable to help with her limited skillset

Related to the above, Sarah articulates the difficulty in remaining within her scope of practice, especially in terms of patient acuity and treatment time needed to address more chronic issues with patients. When asked about whether she ever feels that she is practicing outside of her scope, she agrees that is often feels that way.

Yes. And that could be with parenting issues, because I’m not a parent. It can be with very intense grief; I’ve run into that. When someone has acute psychiatric or just things I’m not used to dealing with, absolutely. And we’re not really – we’re not psychiatrists either. I do have a patient that I see in BMC who has a lot of psychiatric history and I
agenda set and told her the expectations, that this is just to talk about recent grief, trauma, not to guide all her psychiatric care because that would be overwhelming. The patient ended up being a paranoid schizophrenic and I was like nope, can’t handle all of that. We don’t really have the time and training to provide for all the patients that need it and so we can only kind of triage for the people who are most acutely in need, and it just sometimes feels very ineffective.

Further, not being able to give the time, specialized support, or therapeutic expertise the patient needs in that moment sometimes generates a feeling of being unable to help a patient, which Sarah notes is difficult to sit with.

Yeah. People also get really irate when they’re struggling with insomnia, and they just want something that’ll put them out. And the only time I’ve also seen that is in like acute grief or adjustment reactions where because they’re so overwhelmed with the emotion they just want something that will knock them out. They don’t want to feel so much emotion. And that’s not a comfortable conversation….knowing that they have to go through that pain and talking to them about that, I’m like I’m so sorry that you’re going through this and there’s nothing that I can give you that will make it better, and it will probably just make it worse; it’ll prolong how long you’re feeling this way.

**Relying on the support of collaborative or interdisciplinary care**

Sarah discussed the usefulness of having access to other specialists that can help support her patients.

I don’t always need them but there’s definitely been times where I’m floundering and I don’t know what to do and then I go either ask for help, or if they’re in the room, look at them with pleading eyes, and they’ve definitely jumped in before. We have a wonderful clinical care team made up of a social worker, nurse care manager, clinical pharmacist, a behavioral health specialist, our diabetes educator, and our substance abuse social worker, like she deals with all that stuff. So, we definitely have a wonderful team for dealing with very complex issues. If their biggest stressor is taking care of their adult child because of their special needs, I bring in the social worker to help find adult daycare, or you can get paid to be a caregiver for a family member at a certain age.
Taking this one step further, Sarah discussed the influence this type of support has on her experience of providing care to this population.

...It can feel really powerless to have patients come in and they’re asking – like their biggest concern is asking for help with rent or housing insecurity or food insecurity and it’s like ugh, all I can do is offer medications. At least I can refer to someone else who may be able to help with that. Because a lot of people have social needs and not just medical needs.

Cecelia

Cecelia is a female identifying internal medicine physician with administrative and clinical duties. She presents with a more behaviorally oriented philosophy of care, frequently citing an awareness of safety protocols and controlled medication protocols when working in a busy urban internal medicine practice. Issues of complex psychopharmacology, including treatment for chronic pain, she notes, are beyond her scope, though frequent in her practice setting. She also highlights the importance of physician autonomy and colleague support in treating challenging populations.

Acknowledging the lack of access to psychiatry or other behavioral health support

Cecelia frequently mentioned the difficulty of not having enough timely access to psychiatry or other behavioral health support for her patients. She notes having a specialist available when the patient is in the room is ideal and takes some of the burden of care off of the primary care physician to address all of a patient’s needs, particularly in cases where a patient needs to be deescalated.

When you have that patient who is acting up, acting out, who you can’t get out of the room, sometimes it takes a behavioral health specialist to come in...That’s a tough one, when you don’t have a point of care...That does not make that visit easy....Right now we have someone who helps out I think eight hours a week. We can text them. We do place referrals. But the toughest situation is when you have someone in the room and you need
them now. That’s when we’re stuck. Yeah, so that’s what you’re hoping to gain with this new person, getting somebody who is actually on site. It’s only going to be 0.5, we’re sharing them with someone else, and administration already knows that this is a temporary fix, that we’re going to need someone 1.0 because there’s just so much behavioral health need in the practice…. I need to refer quickly for certain things. I don’t think that they need to be with me, like in the next room. I just need them seen for things I can’t handle.… I mean, I’m very aware there’s just not enough psychiatrists to go around, but primary care is the same thing. We have the same thing. I’m dealing with heart failure, all the gaps of care, the mammograms, there’s only so much you can handle, you know?

**Awareness of safety procedures for threatening patients and maintaining an awareness of own safety in the room**

Safety was an important element of the conversation with Cecelia, including personal and collegial safety and safety procedures for disruptive patients. It was apparent that this was a topic that was frequently on Cecelia’s mind, particularly the safety of her colleagues.

So, safety of the provider, safety of your staff, oh my gosh, that is always on our mind. At what point are you going to have someone come in with a weapon that is not disclosed? Security does come up and they’re very timely, but they don’t have weapons. They don’t have anything other than a phone call, call the police. So, you have a couple of people that could come up and help, they’re in a uniform, but they have their limitations also. I’m at the mercy of [local police], hurry up, get here. So, there was a gentleman who was a new patient and was off all of his medications and he was interfering with the space of the provider, the personal space, and the personal space of staff. And the threats, they weren’t what he was going to do, it was a generalized threat, but we realized it was because he was off his medication, and luckily a family member came in.

Cecilia discussed what might help make her feel safer in these situations, including adjustments to the physical workspace and additional training.

*We’ve already looked into that question. We have panic buttons, number one, we have them, but we have to get them in certain other areas. To feel safe, barriers. Creating barriers. But once you’re in the room – so training. Further training of how to get out of a situation would be important. Training for all your personnel and all providers. How do you – I know I was trained; I had a recommendation by someone in the network that*
actually saved my life years ago. He mentioned always back out of a room, never turn your back to a patient. And it saved my life. So further training would make me feel safe.

**Difficulty managing complex psychopharmacology and addressing chronic pain issues**

Cecelia described treating a population with a multitude of chronic psychiatric and medical issues, including chronic pain. She describes in detail the challenges of treating this population while remaining firm with her own limits and boundaries as a prescriber.

You know, getting back to the easiest scenario for you to understand would be the patient is coming in asking for the Percocet. It’s very fresh in my mind because it’s happened already three times with a certain patient over the last three weeks. I think you, number one, have to remain firm and not let them bully – bully, threaten. Explaining this is what we’re going to do. And firmness, because if you don’t have firmness, that patient could be there for four hours and that’s what happened. I had to let a patient know, your visit has ended, because we were stuck. He wanted the Percocet and was on three mental health medications and that wasn’t going to happen. But we gave him – we went up on other medications. So, we sort of came up with a plan, in answer to your question, that would hopefully resolve his pain until he was able to get to pain management. So, we have a Plan B without falling through the cracks of Plan A, what his agenda was. You sometimes cannot do what they’re asking for, or you’ll go to jail yourself.

Cecelia described a time before such limits were in place, when her practice was overwhelmed by patients with chronic pain issues as well as co-occurring behavioral health issues, and the struggle physicians had to manage these two things effectively.

So, for example, if they would come to us tomorrow and say you now need to see patients with chronic pain, we would fight back. We would – not fist fight, we would be very strong to make them aware of the why it’s not a good fit for that. And this is what will happen if you insist...You open, and it’s not – we came from a very dark world of patients. We had maybe 40, 50, 60 patients would be coming by for chronic pain. That was maybe 10, 12 years ago. And we’ve come a long way. That part is much better. It’s not that we’re pushing it to other practices, we never refer out unless they truly have – patients with chronic pain syndromes, absolutely, because of a diagnosis, like a rheumatoid disorder, or a chronic back – trauma, absolutely. If I was in that pain, I would want – but that really should be in pain management. This is not the right practice
with residents to have that type of structure, that model for seeing patients with chronic pain. It opens up the door.

Cecelia describes one of the biggest challenges to her skill set as prescribing complex combinations of psychiatric meds without the proper training or support.

...And also, medication, how to co-administer. Now, what is it called? Amplify, or intensified treatments. I’m not really well-trained other than adding Wellbutrin onto a SSRI, and then I worry about oh my god, am I going to cause serotonin syndrome? So mixing medications is a huge deficit for primary care doctors.... So it’s medicines that are thrown – it’s one of those darned if you do, darned if you don’t. If the patient doesn’t get the medication, they run the risk of going back to being readmitted, but now it’s on us, I didn’t even know it exists, so what’s the risk to us?

**Acknowledging the limits of her control and scope of practice**

Cecelia notes frequently in this discussion that behavioral health needs are just like any other specialty need that requires time and training, elements that are in short supply in primary care.

_Over the long term, we could not add that to our scope because we have so much with other disease states like diabetes and hypertension. The flipside to that is would a psychiatrist be able to add treatment of diabetes to his schedule? Okay? Or hypertension. You know, they had a year training of it. All psychiatrists go through – well, maybe a little bit less than a year. They go through X amount of training, but could you imagine adding that onto their schedule? So there’s no way a primary care doctor could tackle everything. We can’t take out gallbladders. I would have to work 24 hours a day to do everything._

**Relying on the support of collaborative or interdisciplinary care**

Cecelia highlights that working in a high stress environment with challenging populations requires the support of colleagues and other disciplines to make the work manageable and rewarding. She describes what this kind of support looks like.
We refer them to behavioral health services, that’s the support, because there are definitely patients that need therapy and then there’s patients, because of their disease state, they need to be managed by a specialist. So that’s our support, saying this person needs to be moved onto the right provider.

I think our approach is – I’m very supported with my colleagues. I support them, they support me. We’re very close. We’ve all had our share of things in our personal lives. But when it comes to being a physician, I love what I do...
Chapter 7: Burnout Participant Results and Pen Portraits

Table 6 includes the scores on the three burnout subscales for burnout participants. Participants in this category scored high on emotional exhaustion and depersonalization (at or above cut-off points of 21.49 and 10.87, respectively).

Table 6

<table>
<thead>
<tr>
<th>Participant</th>
<th>EE</th>
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<tbody>
<tr>
<td>Jenny</td>
<td>26</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Holly</td>
<td>29</td>
<td>17</td>
<td>39</td>
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The following is the set of pen portraits for this burnout group.

Jenny

Jenny is a female identifying family medicine physician with full time clinical duties. She is frank about her struggles with treating this patient population within the confines of the limited scope of primary care and how this often leaves her feeling as if she is unable to help her patients. She values giving time to her patients, even when she doesn’t have it, especially with behavioral health patients whose concerns require more time to listen to and to validate. She articulates relying heavily on her training in integrated behavioral health and feels that as a family physician she has an opportunity to experience the unique nature of treating behavioral health issues within their family context. She is open about the encounters she finds successful, and values the need to treat this population, albeit with more support.
Acknowledging the limited scope of primary care to treat behavioral health issues and feeling unable to help patients

Jenny is forthcoming with her feelings about being pushed to the limit of her training and having to set boundaries with patients about the limits of her scope of practice, particularly patients who have been resistant to seeking mental health treatment. She acknowledges that this leaves her feeling unable to help the patient, though at the same time, with the resolve to set expectations about what type of treatment she can and can’t provide.

...You know, if someone is talking to me for an hour but they don’t want to see a psychology professional or a mental health professional, I have to say, like, hey, you just talked to me for an hour, clearly it would really benefit to talk to a mental health professional, and eventually, like, while I can give some really brief intervention and some initial counseling, I am not a mental health professional, and people come to me as if I were. And that can be – I can feel that I’m not qualified to really be having those conversations other than listening, which is helpful, of course, but sometimes it’s like okay, I’m the doctor and I can listen, we can talk about initial behavioral treatments and medications, but I really need you to see a mental health professional...I feel really insecure about that. But, you know, like, people sometimes are asking me – I don’t know if they want advice or not, but I don’t want to necessarily give advice. I have a teacher who was really, really stressed out and she thought that her administrators were out to get her, and she just comes and talks to me for like an hour visit. I’m not really sure what you want me to do. Like, the situation, I can give you Zoloft to help you cope with it, but as a physician, I can’t really advise you what you should do in this situation. I’m not there with you and I’m not a mental health professional...So that can be challenging.

Recognizing the constraints and importance of time and struggling to keep up with administrative tasks

Jenny has a good handle on her strengths when it comes to working with patients with behavioral health issues and maintains an awareness of the need to take extra time with them, even if it means she is behind the rest of her day.
I think I’ve always been a really – I think a good listener, a decent listener, so I think probably I just let them talk, which is hard on my schedule. It’s helpful because I think just having someone listen to them often is pretty helpful. I had a post-partum mom last night who was, like, just, you know, talking about everything she was going through and at the end she was like, wow, I feel so much better. Great. So time, give them time….So most of my visits are 15 or 30 minutes, but those – the mental health and behavioral health, I mean, they tend to always be the ones that put me behind for the day, so sometimes they run for 45 minutes or an hour, so that’s hard…if we know ahead of time, I have pretty good flexibility in my schedule and my receptionist might know the patients that need a little bit more time, historically.

Additionally, she notes that increased time spent trying to keep up with administrative tasks can significantly impact her work/life balance if she allows it to.

Mostly, lately, it’s been my struggle with just churning and being on notes constantly and it’s really trying to be – keep up with it and be on time and have all my notes done. I’ve cut back on my hours because I have to be there for my kids sometimes. I’m ending up, like, leaving a lot of days just really sort of flustered and feeling like, oh, there were messages I didn’t get to and notes I didn’t finish writing and there’s results I need to get to tomorrow. I think I do a good job with sorting through and picking out the things that need priority, letting the other stuff go until tomorrow if appropriate. That’s just been my latest struggle.

**Relying on training in integrated care**

Jenny felt that she was an exception in terms of how much behavioral health training she received and was able to name this training as a significant factor in her ability to manage this patient population.

*I think I lucked out, honestly. My third year in med school psychiatry rotation was at an acute crisis center and the physicians weren’t all that interested in having us follow them around, so we spent most of our time with the psychologists, just going to, like, individual sessions and group therapy all day. I spent some time with the psychiatrist doing like, intake, and every now and then we would round with them, and we went to, like, the morning meeting where they discuss between the case worker, the psychiatrist, the psychologist, all the patients, what was going on. It was really, really helpful. And I think, like, he did, at the time, I didn’t really know what this psychologist was doing, but I think he was doing a good amount of cognitive-behavioral therapy but really brief and really helpful and to the point, like, right now, when you’re angry, it’s learning to be*
okay that you feel angry, it’s okay to feel angry, but you don’t have to, like, punch a hole in the wall, really, like, in the moment stuff which I felt was, like, super helpful. It has really stayed with me until this day, the therapy, or the counseling he was giving. So that was, I think, really, really helpful for me....I rotated with a pediatric psychiatrist as a resident and she was really great too. She did a lot of talk therapy with her patients, actually, and a lot of teaching. So that was helpful.

She goes further to explain her natural interest in behavioral health and how this was nurtured in an educational context in her exposure to different mental health professionals, including psychiatrists and psychologists.

_I mean, again, I’m interested in psychiatry, so I was probably more alert doing those times. Someone will be like oh, we didn’t learn about that. I’m like, well, we did, you just weren’t paying attention. But yeah, yeah, I think so. Between, you know, pharmacology class, we had a great psychiatrist that he’d come where I went, give lectures, he was pretty funny, and a lot of things he’s said have stuck with me too. And then in residency we had, like, Balint group, we had a psychologist, and she was really – I felt that was really helpful too, those discussions that we would have, and some of her talks – she would talk about if you have patients with a behavioral problem too, she would help us with what that patient might be experiencing, kind of in brief terms, but discussing an overview, which I thought was really helpful for at least initial counseling for patients._

**Acknowledging the unique nature of treating behavioral health issues within the family context**

Being a family physician has offered Jenny a unique perspective, one she articulates when discussing what it is like to treat behavioral health issues within a family context. Seeing multiple patients from one family, including children, provides her with a more holistic picture of the stressors each person may be dealing with, forcing her to grapple with issues of personal bias and ethics.

_But yeah, I mean sometimes it’s, you know, I’m not going to necessarily – especially as a family doctor, their significant other or siblings or parents might be patients of our office as well, and so I keep reassuring that nothing you say leaves this space unless you give permission....especially – well, there was one couple, there were custody issues and there was a violent incident and a protective order. Thankfully the husband actually moved_
away so he’s not my patient anymore... And actually I had a lot of empathy for him. He was going through a very hard time too. It’s just a completely different patient-doctor relationship in that situation even if I may have my biases.

**Feelings connected to successful encounters with patients**

Despite her struggles to manage her time and maintain an appropriate work/life balance, Jenny reports truly loving what she does, particularly her work with patients who have behavioral health needs. She is enthusiastic about the rewards she sees in working with this population.

*Honestly, I love psychiatry and I think that the patients that I do see that do, you know, really do the things that we discussed and sometimes medication, sometimes not, and when they come back thriving and feeling better, that makes me feel really, really good. Some of the most rewarding patients I have I think are people who I’ve helped with their struggles with anxiety, depression, and they’re feeling better... So I’ve had a lot of experience and I feel like it’s something that – I do, sometimes the visits, mental health visits can be draining at the end of the day, but I feel like sometimes those are the visits that make me feel like I’m glad I went to work that day, that I helped this person, or hopefully helped them. So, I think probably just that I enjoy mental health in general.*

**Holly**

Holly is a female identifying family medicine physician who has full time clinical responsibilities. She highlights the rewards of treating patients with behavioral health needs alongside the challenges of managing this population with little psychiatric help for them. She is hyperaware of the constraints and benefits of time with these patients, noting that she often becomes anxious when she is over her time and running behind on her next patient and also when she feels unable to help them with their concerns. She demonstrates a strong awareness of brief therapeutic techniques she can and has used with her patients and highlights the value of having the support of collaborative or interdisciplinary care to treat this patient population.
Utilizing brief therapeutic techniques

Holly presents as more aware than most of the physicians in the study about what therapeutic techniques she can utilize with her patients as well as the utility of taking the time to these transfer skills. She appears ready to make the most out of a visit by imparting to the patient some small teaching point or coping skill to help them manage their behavioral health condition once they leave the office.

I try to find things that they can do to help themselves. Like there’s always a coping skill that you can teach the patient, umm, even just something like accepting a situation or not accepting as much responsibility for things that aren’t theirs, like I always try to teach them something small that they can carry with them or try to maybe reframe a situation, you know, to improve their outlook. Cause you know those things; I’ve had patients come back and say, ‘Yeah that really helped me’. For example, I taught someone some belly breathing one time for anxiety. She was ok with medication, she didn’t want to do counseling, so I taught her some belly breathing, and she was like ‘That really worked, I haven’t had to use the medicine I needed like I thought I would’. So, I try to do those kinds of things.

Awareness of the constraints and importance of time

Holly names time as one of the biggest strains on the relationships she has with her patients who have behavioral health needs. She notes that these patients often take up more time talking about various non-medical concerns rather than focusing on the medical reason for their visit.

Yeah, sometimes it’s time. But like, they have a lot to say and talk about that is not necessarily medical it’s probably more, it’s probably more [psychiatric], and if I have time, I will absolutely do it, but I don’t always have time, so that’s probably the biggest strain.
Holly describes the length of her visits and the role this plays on treating these patients. She notes that despite some flexibility with visit times, she often experiences anxiety over having to cut visits short or keep patients waiting because she is over time.

They’re automatically 15 minutes, but I can say ‘This patient always needs 30’ umm or this visit type like always for depression and anxiety the staff will schedule it for 30 minutes especially if it’s like a new diagnosis or patient coming with this complaint. So that helps a lot. So you just automatically have time....I struggle with umm wanting to like do everything for everybody on time. And that can be really impossible (laughs).

Managing difficult feelings related to the job

Related to a lack of time, Holly describes difficulty managing her emotions when she is running late, describing a sense of tenseness and worry that is she keeping people waiting.

And so then I’ll get in my head and I’ll just get anxious. I’ll worry about being late, I won’t stay present in the moment and then you know I think I feel like I’ll get like a sick stomach, and tight shoulders, and that kind of thing. So, on a day when it’s just plain old busy, and then you have somebody coming in with mental health which takes patients being calm and time and I just didn’t have that. You know, feeling inadequate. Yeah, I don’t like people waiting on me, you know? I don’t know why. Even if they call, I wanna get back to them as soon as possible, like it’s just, it’s like something that I fixate on. Umm, and of course I wanna be done with my workday on time so I can go home and spend a little time with my family before we go to bed, so there’s always that in my brain.

When asked about any notable experiences with patients with behavioral health needs over the last six months, Holly mentions other difficult feelings that have come up for her.

Holly: Yeah, so actually the guy who umm who had a legal charge against him, umm, the charge was sexual assault, and like the description of what happened really just kinda grossed me out. You know, and I like, I was told about it, umm, it was in the news, and then I saw this patient for depression and he was reporting like real depressive symptoms, thoughts of self-harm and everything, and I found it really, really challenging
to be compassionate with him. All I could think about was, you know, what he was accused of. So, it was really hard to be present for him, cause he was talking about the situation and how he was innocent and why he was innocent and I’m just like I don’t believe you. And most of the time it doesn’t matter if I believe a patient or not, I’m like this is their experience. I had a really hard time separating, you know, out from that... I felt guilty actually because you know I was like well, maybe my care was compromised...maybe not, you know I made sure he had the appropriate medication and crisis referral, and I just didn’t feel like I supported his emotional health the way I would someone who didn’t have that circumstance. So, I felt guilty about that and repulsed and that kind of thing.

Holly also mentions experiencing a patient death by suicide, and when asked, notes that there was a lack of debriefing support provided by her practice/agency to work through this experience.

Holly: ...He was in the military and then in prison and I could tell he just wasn’t like treating his mental health, I could tell that. And like every visit we’d talk about it. He had other issues too and he always steered the conversation to those and really just kind of buried his mental health. And I remember hearing I think it was through the news and also one of my other patients was commenting that he, yep, he died by suicide. And it was kind of like, he never reported suicidal ideations but I kind of felt not surprised. Because he really just didn’t engage with it at all. And it was kinda like I kind of figured something like that might happen. And of course, I felt sad about it, I didn’t feel like I did anything wrong, which was kind of surprising, you know. I always talked with him about his mental health and he just wasn’t very forthcoming, so there wasn’t....I couldn’t get him to open up about it. And I didn’t know him very long, either. So, yeah. It was sad for sure. But it wasn’t like one of my patients that I’ve had a relationship with for a long time and it was surprising to me, so.

Researcher: Right, right. Do you guys have any process of debriefing if it’s something like that, you know, where it’s maybe a patient that the practice has known for a long time, or...?

Holly: Nothing formal.

She also mentions a struggling with times where she feels unable to help a patient, and the difficulty with accepting this.

...And I think the other thing too is if I can’t really do much for them. Like maybe they’re just elderly and lonely and isolated and as a result depressed and there’s not much I can
do about that if they’re not willing to take a medication. So that’s challenging. I find those very challenging personally, I don’t know how the patients feel about it, but like you just, you want to do something to help them, what can you do?

**Utilizing the support of interdisciplinary or collaborative care**

When asked about what makes working with this patient population easier, Holly notes that having physician colleagues she can go to for support, as well as any other available integrated team that can address behavioral health needs, helps support her work with these patients.

Yeah so I mean a lot of times, kinda blowing off steam to my colleagues, that’s really helpful and saying this patient is going through this, or it was difficult for me to see this patient, umm and definitely like the scheduling privilege I talked about, making more time for some of these people, that’s really helpful. Just having anyone to vent to, and kind of umm, you know bounce off my feelings off them and sometimes they can like reset my expectations, I have a lot of unrealistic expectations of myself, right, so they can help me with that. And they can also, you know, validate what you’ve done medically too. Like a lot of times I’ll say, ‘Should I have done something different here’ and they’ll say whatever and that’s so helpful. Umm, we don’t have, I mean we have the clinical care team through [hospital network] that we can refer people to, and that’s hugely helpful for the social worker in particular because of medication costs. Umm, a lot of our patients actually have commercial insurance, so we end up having, like when they need counseling, they tend to use that as opposed to the clinical care team. So, there’s not a lot of support in the office for that kind of thing.

**Acknowledging the rewards in treating this population**

Holly’s interview helped to shape the interview guide, as she is the first physician to acknowledge, unprompted, the rewards of treating patients with behavioral health needs in her practice. When asked if there is anything else she wants to add that I might have asked about, this is what she mentioned.

Umm. I think it’s oddly satisfactory, like treating these people. Like I you know, some health conditions you may not be comfortable treating and you put it off to the specialist, but like I don’t know, I feel more comfortable than most treating depression and anxiety,
not necessarily Bipolar illness that kind of thing. So, when you see somebody improve
with those symptoms, it’s really rewarding. So, it’s umm, you know, it’s an effort and
time intensive, but it can be something that really is meaningful to a person’s life. And I
really feel like ‘I can help with this’.
Chapter 8: Uncategorized Pen Portraits

There were two participants, that despite the best efforts of the researcher, did not complete requests to fill out the survey measure for the study, and thus their portraits could not be analyzed via a corresponding burnout profile. However, both participants did complete their interviews and provided information that aided in understanding the research question. For this reason, their uncategorized pen portraits are included below.

Kelly

Kelly is a female identifying family medicine physician with full time clinical responsibilities with some limited administrative components, mostly working with residents. She utilizes a variety of relational, patient centered approaches when interacting with her patients with behavioral health needs, including validation, meeting the patient where they are, and developing emotional safety in the visit. She also maintains an awareness of systemic factors that influence her work with these patients, including the role of social determinants of health within the low resourced, urban community of patients she treats. She maintains an awareness of the burnout potential of herself and others, particularly with the lack of access to psychiatric resources for helping these patients, while recognizing the rewards of treating behavioral health needs in her practice.

Validating patient experiences and developing a sense of emotional safety

Kelly talks about relating to patients through validating their concerns up front. She uses the example of patients that come in experiencing grief.

...[I tell] my residents is you can’t medicate somebody out of grief. You know, sometimes if there’s a lot going on with them, they have the right to feel that thing that they’re feeling, and helping guide them through it is more what our job is, to kind of be like a point of reference that they can come back to or to inquire, how are things going today? What can we do today? I understand that you feel like crap. I understand that it’s hard for us to get you into some of the other specialists that you really want to be seeing right now. I’m here for you.
This thread of validation helps to build a sense of emotional safety with the patient in the visit, letting them know it’s ok to discuss difficult topics.

_Just giving them permission that if they want to go there, they can, and if they’re not ready or if they have support other ways and they want me to stay in my lane, that’s perfectly fine as well. But also, I hope it sets me up as somebody they can trust. So, I think that sometimes people are afraid to tell you something they’re not proud of or they think makes them look bad. So, again, it’s trying to encourage them that they can say anything within the space as long as it’s not something that insinuates them in some sort of a crime against a child, I’m probably not going to do anything. I’m not going to think any less of you. Or I really try hard not to._

**Meeting the patient where they are**

Both validating the patient and building a sense of emotional safety are ways in which Kelly meets the patient ‘where they are’, a core tenant of social work practice that seems to permeate Kelly’s approach in family medicine. She describes this approach using the example of goal setting with a patient.

_A lot of times if I can see that there’s no harm in their goal, it may not be what I’ve chosen for them, there’s really no harm in it. It’s at least even with where we’re at today, if not moving in a positive direction. I’ll be like great, that sounds like a great goal. What’s that going to look like? And then just get them to commit to that goal, even if it wouldn’t have been mine. So, if I can do that, then I’ll do that, because then the patient has made that decision, they’ve come up with this and they feel good about it being their choice._

**Recognizing the role of social determinants of health in treating patients with behavioral health needs**

Kelly has a sharp sense of the role of social determinants of health in the population of patients she treats, particularly those with behavioral health needs. She describes some of these issues, particularly the role of trauma and poverty, and the challenges they present for the patient and the treatment team.

_...There’s a lot of trauma. There’s a lot of the challenges of poverty. There’s a lot of people just not treating each other well. And then you throw on the pandemic and the emotional [assault] of the staff, and yeah, it’s exhausting….If [the patient is] depressed because they’re living out of their car, giving them a pill or counseling is probably not going to solve the problem. So, what are the other support agencies that we have to try and deal with so that we’re not just saying, oh, yeah. Because it makes sense that you’re depressed. We need something that’s going to help that_
thing....I mean, yes, and some of our folks who work in very under-resourced urban areas probably see something akin to a war-time experience...Trauma is trauma, whether it's politically organized or not.

**Acknowledging the lack of access to psychiatry or other behavioral health support and the limited scope of primary care practice**

Kelly was able to offer a lot of perspective on the challenges of not being able to access psychiatry and how this extends to the limits within her scope of practice. She begins by describing her experience moving to the area and determining what behavioral health resources were available for her patients.

I mean, I was new to the area. I was not sure how to make a referral. We were all paper charts when I first started. How do you find your resources? How do you make a good, clear recommendation to a patient? How do you make a referral to a place in town? And what do you know about them? What do you know about that place in town? How busy are they? What resources do they have? In that kind of environment, it absolutely sucks because it's like you almost need to decide, am I going to become the counselor? Or am I going to kind of, you know, create that boundary that basically says, I just can't do that in addition to the rest of the things I'm doing, but I also don't really know how to make sure I get you to the right place. So that's definitely informed my decisions on where I choose to work.

Kelly goes on to describe how the strain of not having specialized training undermines her ability to support the specific needs of the patient population that she treats.

So, I think the biggest strain is just that I know that I don’t have the training to do the work that they need but also know that it will be very difficult in some cases to help them access the kind of help that they need. So it’s like, we can see it, we know what we need to do here, but I know I don’t have the skills to do it and it’s going to be really hard to get them to the right place to do it, especially for trauma-informed therapy or addiction psychiatry or really good addiction counseling with people who also have mental health disorders, those are really challenging.

**Rewards of treating this population and awareness of the burnout potential of self and others**

Kelly connects both the rewards of treating patients with behavioral health needs, particularly those that are low resourced and high need, with the potential for burnout. She discusses her sense of what this means for her in the long term.

Yep, yep. I like to say I’m looking for a new job all the time. Not because I hate what I do, but just because I have to figure – I’m always thinking about, is this where I’m going to be forever?
Probably not. And if it’s not, then where do I want to be and how do I make the choices to get there? And some part of it is the intensity of the needs of some of the patients in the population that I care for. It is challenging. But so far, I mean – I can’t see me also just working in some boutique practice in the suburbs because I’d be bored. When you get to do this kind of work and you’re really kind of working to the top of your scope or doing things that some of your colleagues don’t do, it’s like ugh, you mean I might have to work there where they send everybody to the psychiatrist for Lexapro? Why would I do that? Why would I do that, I’d be so bored.

Bethany

Bethany is a female identifying internal medicine physician with full time clinical duties. She maintains that learning to listen to patients and have them tell their story is important in building rapport and trust, though she notes that often she is limited in the amount and type of support she can provide within her primary care scope. She acknowledges being situated in a practice setting with limited access to psychiatric resources, and appears acutely aware, as a crying child in the background of her interview would indicate, of her need for better work/life balance.

Recognizes the importance of listening in establishing rapport

Bethany notes the value of listening as a way of establishing trust, rapport, and safety with her patients, particularly those with trauma histories. Close follow up, as she notes, is often a part of this process, with the development of a rapport unfolding over time.

I think getting to know them, hear their story, ask them about….I try to do frequent follow ups, especially with my patients that are really struggling with anxiety; um so that might be, I mean obviously we have time limitations, that might be to have them come back every 6 to 2 months, when it’s like really active. So, I think over time you can definitely build rapport, and you can build rapport just by getting to know them and their history and ask them about things that have been going on. And I’ve definitely found that like after I meet someone a couple more times, they seem to develop more of a rapport than obviously the first time that you meet them, that’s obviously harder to develop. I just try to be open and listen to what they say. I’m not sure that there’s anything in particular that I do differently. I try to use empathy and just try to connect with them, with things that they feel comfortable with me.
Hesitancy and negotiations surrounding prescribing controlled substances

One aspect of Bethany’s daily practice that she mentions is the necessity of negotiating with patients about the prescription of controlled medications, such as medications for anxiety or chronic pain. Bethany describes the process of working with a patient to taper off of controlled meds and how the patient’s willingness to do this typically guides the timing of the process.

Researcher: Yep. Do you have people that will agree to a taper?

Bethany: I actually am surprised to find a lot of patients that agree to it. A lot of people who are initially really resistant but then like find that they can do it and it’s fine. It actually ends up working out. And then I also have patients who are like we taper; we get to a certain point, at least it’s a little bit less Xanax, or whatever, and at least it was like, a reduced burden for them. And they, at some point they might just tell me like ‘I just really still need this for now’. And sometimes I’ll continue it for a little while and re-address it with them later. My approach to those where I feel really uncomfortable prescribing something is just really doing a slow taper, like a legitimately really slow taper so that I know that they’re not going through withdrawal so that you can kind of slowly work on just getting them on another medication, and in the meantime hoping that they can get a mental health provider in a 6 month period or whatnot.

Bethany notes that with some patients, this type of negotiation process is not effective, and she appears to take a more behavioral approach in these cases in order to stay within her clinical scope and comfort zone, despite a patient’s hesitancy.

Every once in a while there’s patients that are just really, really resistant to even any slight adjustment. And I sometimes try to just like respect that opinion and discuss it with them next time at this point. Unless I feel like it’s actually doing them harm. I will like bring it up over time and hope that it sticks. And if I have patient that I really just want to taper, I just like do it, honestly. Like I just say, ‘This is what’s gonna happen, if you want to see someone else, go see somebody else, it’s your choice’, right.

Feeling unable to help within her current scope of practice and acknowledging a lack of access to psychiatry or other behavioral health support

One thing that came up frequently in conversation with Bethany was the frustration inherent in not being able to ease the suffering of her patients with behavioral health needs. She notes this below in the case of a complex patient in which she was unable to find the resources he needed to manage his mental health.
I think in terms of negative things, yeah I mean….I just feel like the ones that are really
difficult…I recently had a patient that came to me really struggling with Bipolar disorder and
telling me things like he’s like yelling at his family and just really feels out of control and really
wants help. And I think maybe he paid some guy, some psychiatrist like $500 and they talked to
him and started him on Depakote. And that’s fine, it kinda helped a little bit. I just don’t feel like I
have the resources to help him.

Relatedly, Bethany discusses the above patient in terms of poor access to care, stating that
she wasn’t able to find him a psychiatrist within the health network she practices in. She
describes this as a contrast to a previous place where she worked where she had better access to
behavioral health support.

...And I can’t get him to a psychiatrist, and he doesn’t have money to pay that guy to talk to him
again. I remember one thing that I used to have at another primary care office was even though
everyone couldn’t access a psychiatrist, we were able to like e-consult or just like send a text
message to one of our psychiatrists through our system, and they would just give us basic advice,
like ‘why don’t you start this patient on Depakote, and why don’t you do this, and then eventually
I’ll see this person. And that was helpful. I feel like that does not exist at [name of hospital
network] either. I just, you’re put in an e-consult and I don’t really get much information out of it
at all.

Feelings surrounding difficult encounters

When asked to describe a difficult day in her practice, Bethany had this to say about a
time when she was a newer and less experienced provider and how she has come to see this
particular incident with a patient as a growth experience.

Hmm. That’s definitely a hard question. I mean there have definitely been hard days. I think I
would say just as I became like a new outpatient provider and didn’t really have as much of a
grasp of how the system works as well, there have definitely been encounters in which I would
say….there was one I remember where like a patient kind of like asked for pain medications and I
basically said ‘No I’m not comfortable’ and there was like a lot of yelling. And I personally did
not know how to handle that at that point. I think I just didn’t have the experience. I’ve definitely
developed mechanisms against that. I remember just feeling really upset, taking it personally,
umm. I did talk to the clinical supervisor at the time, I was at a different site, but they were
supportive which was good. And I think he may have gone in there and just like talked with them
because sometimes that’s something that they would do at that office if a patient was like super
upset. Yeah, and after like, a little while I like realized with time like it’s not actually personal at
all. I think that was a little bit of growth for me.
Recognizing the need for work life balance

In discussing whether or not Bethany has ever considered alternative careers, Bethany makes a clear distinction between what she enjoys clinically at the moment and the burdens of the administrative work that she is tasked with. She frames this in terms of survival, trying to balance her personal and professional life without much room to think of other career options.

Yeah, I mean, I actually wanted to go into primary care. I’m happy with like, the clinical component of it. I think that it becomes burdensome, I’m not 100% that I’m gonna do this for the rest of my life and not transition into something else that might be a little less clinical. Yeah, I mean there have been times where I’ve thought about it, but I just like, it’s not something actively on my mind right now. Like right now I feel like I’m trying to get through my clinic and take care of my kids and that’s basically what I have time for.
Chapter 9: Core Themes Across Portraits

We can think about physician experiences as like any therapeutic relationship, one in which much work occurs both inside and outside of the treatment room. When given the opportunity, these physicians are thoughtful and reflective, at times vulnerable, and acutely aware of their greater powerlessness within the larger system that is healthcare in the United States. The following are the core themes (bold) and subthemes (italicized) that were generated inductively by the researcher as a means of organizing a qualitative discussion of the work of fifteen primary care physicians who treat patients with behavioral health needs in their practice. These themes were drawn from a thematic analysis of interviews and were analyzed both within and across pen portraits.

From the moment the physician enters the room, he or she is practicing within a philosophy of care, one that is very often relational, though depending on the physician and the patient’s presenting problem, may also present as behavioral, or more often a combination of both. Generally, nine out of the fifteen physicians in the study articulated viewing the medical and behavioral as interrelated, with some even relying on their own training in integrated behavioral health as residents or early career physicians. Those with more relational orientations would often ask the patient permission to discuss difficult topics, would maintain an awareness of body language, and would develop scripts or strategies (i.e, personal use of self, personification of illness, active and reflective listening, etc.) to help build rapport and create a sense of emotional safety with patients.

Physicians in the study described additional relational approaches in meeting patients’ needs, including valuing honesty and utilizing collaborative language when
discussing behavioral health issues. Those with a more relational approach also described *personal use of self* in an effort to relate to this population as well as a *reliance on a* ‘natural’ *skillset, affinity, or own personal life lessons* in working with this population.

Behavioral orientations tended to be more common among, though were not exclusive to, physicians treating high numbers of substance abusing or dually diagnosed patients, which a *reliance on protocol* as a protective strategy for the physician, as well as increase in *limit setting strategies* or *hesitancy regarding prescribing controlled substances*. Often, there was a delicate balance of *negotiation* that physicians had to tread when discussing the prescription of controlled medications for conditions such as chronic pain and anxiety. Three physicians in the study stated firmly that this is something that they will not do or reinforced the agency policy that the prescription of these drugs to treat certain conditions should be done sparingly in the primary care setting. For those physicians who frequently saw patients with substance use issues, about three people, in addition to heavily relying on protocol, there was some readiness to utilize a more *‘tough love’ or confrontational approach* should the physician’s willingness to prescribe these medications come under attack by the patient.

The amount of *behavioral health training and experience* among the physicians in the sample varied, with eleven participants having a great deal of these experiences and four having only a psych rotation in medical school or limited experience in residency. Those physicians who did have behavioral health experiences relied heavily on their *training and experiences in integrated healthcare* and their history of *working successfully in a collaborative or integrated environment*, drawing on these experiences in their current work with patients with behavioral health needs. Six physicians with this
type of experience even noted utilizing brief therapeutic techniques with patients in their everyday practice, drawing on something quick and easy that they could do to ease a patient’s discomfort. Only one physician mentioned having very limited behavioral health resources at her disposal in her current practice setting other than the occasional psychiatric consult, a stark shift from her training experiences where she had an abundance.

The care physicians provided was quite patient centered in a variety of ways, and most physicians were quite emphatic about the need to put the patient in charge. Physicians did this by supporting patient autonomy, offering patients a variety of treatment options, and centering what is most important to the patient in the visit. Often these strategies were part of a larger goal prevalent in primary care and other medical care known as joint decision making. In this way, physicians ensured that they are not taking on the sole responsibility for patients’ treatment but engaging patients’ sense of agency over their own care. Often the patient’s agenda was not dismissed but sought after as a guiding force within the visit. There was a general awareness that the agenda of the physician is the patient’s agenda, and the skill with which the physician highlighted this alignment in the visit could often head off unnecessary conflict.

Issues of physician safety were a recurrent theme throughout many of these discussions, particularly with those physicians who worked with populations of patients that were significantly under-resourced or experienced severe chronic pain or substance use. There was an awareness of the need to protect clinician safety within the patient encounter in situations where a patient interaction escalated or the need for physician support was acute. In these instances, physicians described the need for developing
strategies to protect clinician safety as well as maintaining an awareness of their own safety in the room with the patient.

Overall, when describing their experiences in the room with their patients, thirteen out of fifteen participants highlighted the theme of time in some way: its importance, its constraints, and the ways in which they attempted to leverage it in order to build relationships with their patients with behavioral health needs. These physicians readily admitted that treating patients with behavioral health needs takes time, often over and above the allotted 15 or 20 minutes they are given. There was a palpable feeling of pressure physicians articulated as they described the constraints of time, illustrated by the number of clinical check boxes they needed to tick off in a short visit, in addition to addressing the patient’s presenting problem, including anything behavioral health related. The importance of time was outlined in terms of the need to complete accurate psychiatric diagnosis, medication prescriptions, and referrals to further support if needed.

Time was also discussed in terms of the importance of continuity of care with behavioral health patients. To prevent re-traumatization and to maintain and strengthen the relationship, physicians saw and appreciated the need for this continuity, despite many not being able to provide it due to packed patient schedules. For those physicians who were able to maintain some continuity, they often leveraged time in building relationships with these patients, utilizing the relationship and history they had built up with a patient over months or even years to help support their behavioral health needs, particularly if they noticed a marked change in behavior over time.

In asking physicians about their internal experiences outside of the patient encounter, in the brief spaces where they have the time and clarity to process their day-to-
day interactions, physicians acknowledged the ups and downs within their own

emotional health management. They spent time identifying difficult feelings they
grappled with after challenging encounters with patients, encounters that often left them
feeling unable to help a patient, due to a lack of resources or limitations in their skillset,
feelings that two of them articulated managing by compartmentalizing or by increasing
their own self-awareness. Particularly when treating patients with controlled medications
or complex psychiatric medications, four physicians reported struggling with the concept
of ‘do no harm’ as outlined in the physicians’ code of ethics. Seven physicians mentioned
actively trying to manage their patients’ expectations of the visit, with one mentioning
the increasingly stressful role of patient evaluations and physician ratings, and the
difficulty in managing conflicts with patients in the context of patient expectations and
evaluations of care within the greater healthcare system.

There were a number of elements that contributed to making the job easier for
physicians, including strengthening interpersonal collaboration with both colleagues and
patients, having access to co-located behavioral health support, and acknowledging the
rewards and successes in treating behavioral health populations. Thirteen of the
physicians studied highlighted the importance of having strong interpersonal
collaboration with other colleagues and with their patients in order to provide the best
possible care. This included having access to behavioral and social resources to provide
the patient with complex psychiatric needs and/or other social determinants of health. It
was important for them to acknowledge the rewards as well as the challenges in treating
these patients, and to highlight some success stories that helped keep them engaged in
their work.
Having a small compendium of successful experiences was just one element that physicians drew on in **combating burnout**. Five of the physicians interviewed for the study had some element of administrative time or other leadership role and cited this as a way of avoiding burnout by **diversifying their skillset, giving them a sense of the ‘big picture’** of their work, and as a means of **balancing the strain of clinical work**. A strong sense of **recognizing the limits of one’s control**, both with regard to psychiatric skillset and ultimately over patient behavior, pervaded the discussion of the emotional impact of working with patients with behavioral health needs. Further, a number of physicians highlighted the importance of **making the connection between physician autonomy and wellness** and **maintaining an awareness of the burnout potential of themselves and their colleagues**. There was a strong sense from participants of **physician burnout as a direct by product of the ‘business of medicine’**.

Lastly, a discussion of **systemic constraints**, generated from a robust discussion of individual experiences, revealed a number of related themes that influence work at the physician level. All fifteen participants, at some point in their interviews, mentioned the **dire lack of access to psychiatry or other behavioral health treatment** either within their health system or in the community, and **general feelings of frustration about providing care to this population without adequate psychiatric support**. When patients did receive psychiatric support outside the health system, there was a recognition of the **poor communication between systems and the influence this has on patient care**, namely leaving the physician in the dark regarding the patient’s psychiatric treatment plan, with little time or staff resources to request and compile outside psychiatric treatment notes to reference. Three of the physicians studied commented more deeply about the issue of
integrated care, postulating on *the structural changes needed for integration to be successful*. This included additional full-time employees, group billing structures, more recognition of the central role of primary care in the greater healthcare system, and acceptance of the shift towards treating behavioral health conditions in primary care.
Chapter 10: Discussion and Implications

Through the use of both in-depth, qualitative interviews and a quantitative survey measure, the Maslach Burnout Inventory for Human Service Professionals-Medical Personnel, the experiences of primary care physicians took shape. Using this survey tool to guide the analysis of qualitative interviews and the creation of pen portraits on each participant as well as the most salient aspects of participant interviews, the richness of these experiences yielded the following core themes across portraits: philosophy of care, behavioral health training and experience, putting the patient in charge, issues of physician safety, time, emotional health management, making the job easier, combating burnout, and systemic constraints. Quantitative analysis informed the organization of the findings further, nesting each portrait into burnout categories derived from Maslach and colleagues (2016) after they conducted a latent profile analysis across their data, in order to address nuances along the burnout-engagement continuum. Those categories are as follows: engaged, overextended, ineffective, disengaged, and burnout. In this study, there were no participants who fell under the disengaged profile.

This study utilized two different yet interrelated theoretical frameworks of the therapeutic relationship, the first developed by Michael Balint, as applied to the doctor-patient relationship in medical practice, and the second developed by Edward Bordin, whose work further developed the concept of the working alliance in psychotherapy. Balint’s work, with its focus on the relationship as the prescribed ‘drug’ for the patient (Balint, 2000; Jones, 2011) highlights the ongoing nature of the relationship with the primary care physician as unfolding over time, which allows the relational component of illness to flourish (Balint, 2000). This concept was reflected in the current findings, in
which one of the most recurrent themes within the sample was related to the importance of time in building relationships with patients with behavioral health needs, whose needs often taken up longer visit times. The concept of building relationships over time was also noted by participants to be characterized by the constraints placed on physician time (visit time, amount of time to complete charting, etc.) and its interference with the development of the relationship.

Further, Bordin’s theory of the working alliance in psychotherapy outlines the significant role of collaboration around which alliance is formed (Horvath & Greenberg, 1994). A strong working alliance, according to Bordin, aligns the demands of the work and the individual personalities of the therapist and the patient (Bordin, 1979). There is an agreement on the goals and tasks of the therapy, as well as bonding between the therapist and the patient (Bordin, 1979). This is not unlike the ‘fit’ between an individual primary care physician and the patient, and it aligns well with the shared decision-making process many study participants described as a core piece of relationship building with patients, one that shares the responsibility for care as well as increases the patient’s autonomy. Overall, physicians in this study describe the process of developing trust and collaboration with behavioral health patients as similar to their patients without these needs, with the main difference being the amount of time it takes to build rapport surrounding complex and sensitive issues, as well as to find appropriate and available treatments.

The importance of the development of trust and collaboration as elements of patient satisfaction have been documented mainly from the perspective of the patient’s experience of their care and the influence of that experience on health outcomes.
In this study, physicians described the process of collaboration as necessary in maintaining patient autonomy and in sharing the responsibility of the patient’s care with the patient themselves. Joint decision making and offering the patient options in terms of psychotropic medications, therapy, etc. were a key part of the way physicians in this study went about collaborating with patients who presented with behavioral health concerns. Aspects of trust building that appeared to be specific to patients with behavioral health needs included asking permission before discussing sensitive information as well as allowing the patient’s story to unfold over time, with the acknowledgement from some physicians that withholding information is often part of the experience of mental illness for some patients.

Physicians described their experiences with patients with behavioral health needs within the frame of their own philosophy of care. Philosophy of care can be understood as a style of practice or orientation, one that encompasses a practitioner’s values and priorities in treating their patients (Marian, et al., 2006). Physicians who were more relationally based had philosophies more oriented towards relationship building elements, including fostering trust and collaboration within the patient-physician relationship. This type of philosophy of care is often associated with family medicine, where physicians are trained to view the patient in their context, attending to the more subjective areas of the medical encounter (Hutchinson & Becker, 2004). Physicians who were more behaviorally based had philosophies that were characterized by more limits and boundary setting, clear expectations of prescribing habits, and an awareness of the need to maintain safety within the medical encounter. Most physicians in this study demonstrated some elements of both
styles, though within the spectrum of burnout profiles, there were clear differences in how this manifested in practice.

Study participants were aware of best practices for treating psychiatric disorders, though at times some were conflicted by efforts to ‘do no harm’ to the patient, resulting in prescribing something that they were not always comfortable prescribing or providing counseling support that they were not qualified to provide until the patient could gain access to specialty behavioral health care. Some physicians in the study described navigating this boundary as a struggle, while others were more firmly planted within what they were willing to provide to patients. There is a sense from those physicians with more firm limits on what they will treat, that treating behavioral health conditions in primary care feels fundamentally different than treating, say, diabetes, or heart disease. Relatedly, nearly all the physicians in the study describe the frustrations of not having enough time within their scheduled visits or support via the accessibility of behavioral health providers, to treat this population to the best of their ability with the appropriate resources. These physicians seemed to be able to easily access other specialists, such as a cardiologist or endocrinologist for consultation on a patient but were not able to easily access psychiatrists.

Though most physicians reported issues with time and access to specialists, those on the more burned-out end of the spectrum seemed to struggle to manage the multiple threats to maintaining a relationally based philosophy of care, in which time and support are essential. Most physicians found the experience of treating this population challenging but extremely rewarding. They describe the rewards of this work as seeing the improvement in mood their patients experience after beginning therapy with a
counselor or starting medications they prescribed; the feedback this provided to physicians appears to help them feel they were part of improving the patient’s health in some small, positive, and productive way.

Engaged participants tended to be the most relationally oriented within their philosophy of care and were quite reflective on their practice. Quotes such as “I find that I want to see what their agenda is and respond to their agenda” (Bob), “I think that’s one of the most important ways to build rapport, is to give the patient space to tell their story” (Thomas), and “…I tell them, I would not be a good physician and would not be able to feel like I was doing an adequate job of taking care of you if you didn’t feel emotionally healthy, too” (Charlene) help illustrate the tendency towards relationship and rapport building as a key component of treating patients with these needs. At least half of engaged participants had administrative time built into their schedule, giving them the opportunity to utilize other skill sets as well as have time away from clinical work. This ‘time away’ seemed to help physicians in this group focus on strengthening areas of connection with patients, including building rapport and communicating more collaboratively about their treatment. Most participants in this group had experience and training related to working with patients with behavioral health needs and appeared confident in utilizing these skills to their satisfaction within the time constraints presented. There was only one person who identified as female in this engaged group, an interesting finding given the total number of women in the study was greater than the total number of men.

Overextended participants were more qualitatively similar to engaged participants than any other profile category; in fact, there were two participants in this category who
was at the ‘borderline’ of engaged and overextended, illustrating that the line between these two categories is a thin one. However, there were some notable differences between these categories. Overextended participants reported feeling more overwhelmed by a lack of time, and though most of them did have specific training working with patients with behavioral health needs, they felt constrained by the limited time they had to spent with these patients, and often had to be more selective about what skills they utilized, so as not to open up a ‘pandora’s box’ of patient problems. Toby illustrates this well when he says “...if we’re sort of towards the end of time and I feel like there’s something else that’s out there, sometimes I won’t go into it, you know, I’ll just try to do a closer follow-up or potentially, you know, engage another resource in the practice or whatever, so our enabling services or behavioral health services...I find it hard sometimes to fit it [in]”. They presented as more acutely aware of the impact of clinical work on the emotional health and safety of the physician and struggled at times to balance patient expectations and the ‘customer service’ aspect of medicine with their own well-being and standard of work. Zaira identifies this by saying, “Yeah there’s a lot of things that are expected of doctors nowadays...I think the most exhausting part of being a doctor these days though is dealing with the expectation that we’re customer service experts”. Interestingly, the distribution of gender within this category (three female identified, one male identified) was almost an exact reverse of the engaged category (four male identified, one female identified). The two female identifying participants in the overextended category were those that scored at the borderline of the engaged and overextended, suggesting the need for interventions that target the burnout potential of female physicians in particular.
Ineffective participants were burdened by multiple roles and struggled to maintain their existing scope of practice with the behavioral health population they treated. This appeared to have the unintended consequence of making them feel less personally accomplished in their work, despite what the reality of their accomplishments would suggest. Teresa, a participant in this category with a high-level administrative role in which she had been successfully in charge of multiple hospital wide projects, articulates this feeling as such: “So, I have had bad days. It tends to be when I’m not able to fulfill my patients’ needs and I’ll hear that feedback from them... It creates a negative feeling of inadequacy, you know?” Participants in this category touched more heavily on the emotional strain of caring for this population, particularly when so many patients in their practices have complex psychopharmacology needs beyond their scope. Sarah, a resident, even utilized the term ‘compassion fatigue’ to describe this drained feeling at the end of a long day, noting that primary care acts as a poor ‘stop gap’ for behavioral health issues, despite her enjoyment of treating this population and wanting to further pursue behavioral medicine in her residency program.

Participants in the burnout category expressed a chronic feeling of being unable to help patients, despite giving freely of their time, and a palpable struggle to maintain a work-life balance. The constraints of time seemed particularly important with this group, and had a physical impact on emotional health, as Holly describes in herself: “And so then I’ll get in my head, and I’ll just get anxious. I’ll worry about being late, I won’t stay present in the moment and then you know I think I feel like I’ll get like a sick stomach, and tight shoulders, and that kind of thing.” Jenny, the other participant in this category, describes the struggle for work life balance as one related to balancing administrative
tasks, clinical work, and family life: “Mostly, lately, it’s been my struggle with just churning and being on notes constantly and it’s really trying to be – keep up with it and be on time and have all my notes done. I’ve cut back on my hours because I have to be there for my kids sometimes. I’m ending up, like, leaving a lot of days just really sort of flustered.” Notably, both Holly and Jenny are female identifying family medicine physicians. Female identifying physicians who are younger, early career professionals, as compared to male identifying family medicine physicians of any age report experiencing higher levels of burnout, particularly emotional exhaustion and depersonalization (Eden, et al., 2020).

Two participants did not fill out the survey measure and thus could not be categorized according to their burnout profiles. However, in returning to their interviews, some common themes emerged which point to the potential profile ranges they may have fallen into had they taken the survey. Kelly, a female identifying, family medicine physician working with a low-resourced, urban population spoke frequently about the challenges in managing a population in dire need of specific psychiatric resources with little to no access to them. This placed pressure on Kelly to assist clients in locating these resources and often helping bridge their prescriptions until some kind of outpatient psychiatric care could be found. She notes the balance between doing the most for her patients and becoming burned out from the constant struggle to keep up with their increasingly complex needs.

So I think the biggest strain is just that I know that I don’t have the training to do the work that they need but also know that it will be very difficult in some cases to help them access the kind of help that they need...especially for trauma-informed therapy or addiction psychiatry....
For these reasons, I hypothesize that she may have fallen somewhere in the engaged-overextended range, perhaps teetering on the border between the two. Similarly, Bethany, a female identifying, internal medicine physician working in a more isolated rural area with poor access to both internal and external psychiatric resources, notes the challenges of treating a population that is frequently in need of care that falls outside her scope of practice, including pain management and complex psychopharmacology. She notes the juggling act of managing her work-life balance, taking care of her family and her patients, as a constant focal point of her days. This leads me to hypothesize that she might fall more in the ineffective-burnout end of the range, as I get the sense that she is overburdened by patients that she feels unable to help or for whom the help she is providing is not sufficient to stabilize their psychiatric symptoms.

Overall, components of burnout, namely levels of emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment, were influenced by systemic factors such as the amount of clinical vs. administrative time the physician had and the amount of behavioral health resources that were accessible to their practice, the latter appearing to be related to the specific location, patient population, and workforce composition of the office. The influence of these systemic factors at the individual physician level was profound; physicians that experienced more burnout were not necessarily functionally ineffective with their patients, though personally, they often felt this way. These physicians were doing all they could, providing every resource or skill within their scope of practice, and yet there was a sense that this was merely a drop in the bucket as compared to what patients actually needed. The feeling of being unable to ease the suffering of a patient who needed behavioral health support and was unable to access
it outside of the limited scope of what the physician could do, plagued all of the physicians in the study, though more so those on the higher end of the burnout spectrum. It is worth noting here that one female identifying participant from the burnout category and one male identifying participant from the engaged category were married, suggesting the need for more exploration of the nature of gendered caregiving work and its toll on physician burnout.

We know that treating behavioral health issues in primary care is more accessible, efficient, cost-effective, and de-stigmatizing for the patient (Wittchen, et al., 2022; Katon, 1995). We also know that the patient-physician relationship is an important anchor to the patient’s overall engagement in the healthcare system and is a central element in medical practice (Noseworthy, 2019; Berry, et al., 2008). Few studies examine the nature of this relationship with patients who have behavioral health needs, and even fewer explore this relational dynamic from the physician perspective. The current study builds on what we know about the importance of the patient-physician relationship and the value of treating behavioral health needs in primary care and expands this to include the perspective of the primary care physician providing this care. Specifically, the research places this care within the context of primary care physician experiences, gaining insight into how the relationship building process feels for them, the emotional impact of providing behavioral health care, and how equipped they feel to provide this care given the training or support they have received. Overwhelmingly, physicians in this study reported that treating this population takes time, time that is not built into the current 15-minute routine visit model.
Strengths and Limitations of the Research

This study employs a new methodology in which pen portraits are organized and analyzed via the burnout profiles derived from participant surveys. To this researcher’s knowledge, there is no study to date linking pen portraits to quantitative surveys. Approaching the research in this way was advantageous because it allowed me to examine the connection in the way participants described their experiences verbally and the way they reported them in a survey format, allowing for any disconnect to emerge. This method was challenging because of the limitations inherent in survey research, including the heightened potential for incomplete or biased responses.

This study had several limitations, including limited geographic area from which participants were drawn, and the inability to collect more demographic information. Due to the COVID-19 pandemic and in general the limited availability of physicians, most interviews were conducted via Zoom©, in which only audio was recorded, not allowing for the subtleties of body language or facial expressions in ways that might have been helpful or interesting.

Reflexivity

Throughout my work on this research, I had been working in primary care as a behavioral health social worker for almost 10 years. I had one perspective as a direct practice clinician: physicians, though well meaning, were often all too eager to dump the ‘fluffy’ stuff of feelings onto the social worker, doing the best they could in a 15-minute appointment, but overall, wanting to avoid treating behavioral health issues at all costs. While some physicians, of course, do fit this description, many do not, and since
completing the research, I have had the privilege to observe a small slice of those who are the polar opposite of my initial flawed perspective. Completing this research has increased my empathy for physicians, particularly those working in primary care, causing me to see them more as allies rather than obstacles. This study has given me the opportunity to hypothesize through research what I suspected in practice, that female identifying physicians are dually burdened (though they may not describe it as such) by the responsibilities of caregiving at home and at work and are differentially impacted in particular by the gendered nature of caretaking tasks, particularly those of mothering, in addition to patient care.

In addition, part of the impetus for asking this research question comes from my personal experience of a specific situation. In working alongside primary care physicians for nearly ten years, co-treating their patients, listening to their struggles with managing the time and emotional energy it takes to effectively treat behavioral health issues, one particular experience stands out. A physician I worked with, who I’ll call Dr. Z., referred a patient with schizophrenia who was just discharged from prison the day before coming for his primary care appointment. Dr. Z. offered him a referral to a partial hospital program, as well as a referral to me, the behavioral health social worker, to follow up. He declined both. By the following week, I came in to work and heard that this patient had committed suicide. Dr. Z. had been given the afternoon off, but was back at work the next day, with a full patient schedule.

**Implications for Social Work Practice and Areas for Further Study**

The findings of this study point to the need for medical social workers to support primary care physicians in providing behavioral health care to their patients. Indeed,
much of the treatment for common behavioral health conditions, including depression and anxiety, continues to take place in primary care settings (Jetty, et al., 2021; Olfson, et al., 2014). Social workers can help support this work by providing behavioral health services alongside primary care physicians as well as by providing education and training to physicians working with behavioral health populations.

With the addition of the Quadruple Aim in healthcare, a codified attempt to address employee wellness and record levels of burnout among healthcare professionals (Menzin, et al., 2020; Bodenheimer, et al., 2014), we need to ask healthcare providers, particularly primary care physicians, how they experience their working relationships with their patients with behavioral health needs and what we as social workers can do to support them in this work. Surveys that capture workplace environment and culture are important, but often miss the specifics of working with certain populations, within the constraints of unique practice environments, and the emotional impact of providing this type of specialized, high demand care.

There was only one person who identified as female in the engaged group. With the current study, more women report feeling overextended, ineffective, and burned out than men. There is existing research comparing the caregiving and domestic responsibilities of female identifying physician-scientists as compared to male identifying physician-scientists (Jolly, et al., 2014), the disproportionate impact of burnout on early career female identifying physicians with caregiving responsibilities through the COVID-19 pandemic (Dillon, et al., 2021), and the declining rate of female identifying physicians in leadership roles due to conflicts with work-life balance (Butkus, et al., 2018). Indeed, previous research has shown that female identifying physicians with young children
reported less burnout when receiving the support of colleagues and a partner or spouse who split household care tasks (McMurray, et al., 2000). Given the study results regarding female identifying primary care physicians treating patients with behavioral health needs and experiences of burnout, exploring caregiving, specifically mothering, in a full time, clinically based, female identifying primary care physician population that treats patients with behavioral health needs and examines the relationship to burnout would be a logical next step.

According to 2018 research, female identifying physicians make up more than one third of the physician workforce and more than half of all medical students in the United States (Butkus, et al., 2018). In addition, the majority of societal care tasks outside of work continue to fall disproportionately to women, historically, women of color, for whom economic exploitation and racial domination has worked in tandem with gender inequality (Jolly, et al., 2014; Collins, 2016). In addition, female identifying physicians tend to see more psychosocially complex patients who require more time and emotional energy to treat, setting them up to be more frustrated and burned out by these interactions as compared to their male identifying counterparts (McMurray, et al., 2000).

In the current findings, all but one female identifying physician reported some aspect of burnout. This was indicated by scores on emotional exhaustion, depersonlization, and reduced personal accomplishment that were above the cut off points calculated for the sample (pg. 19). The more burned-out physicians were, the more difficult it was to maintain their core engagement with patients amid the flurry of administrative time constraints and personal life responsibilities. Female identifying physicians are typically viewed by patients as more patient-centered, responsive, and
warmer, as compared to their male identifying colleagues, though female identifying physicians are not rated higher on measures of satisfaction, as they are expected to embody these relational qualities ‘naturally’ (Hall, et al., 2015). In the current findings, gender precluded a more engaged approach for female identifying physicians because of the amount of burnout they reported experiencing.

Further, there is a significant gap between the demands of working in the United States medical system and societal expectations surrounding gender. Early career female identifying physicians are often delaying life milestones in order to get through residency (Chesak, et al., 2021), and despite the new American Academy of Pediatrics (AAP) recommendation that children be breastfed until the age of two (Wyckoff, 2022) current legislation has not caught up with this edict. The ‘PUMP Act’, a part of the ACA that is dedicated to ensuring that ‘nursing employees have the right to reasonable break time and a place, other than a bathroom, that is shielded from view to express breast milk while at work’ only offers this protection ‘for up to one year after the child’s birth’ (US Department of Labor, 2023). Unsurprisingly, while many female identifying physicians have high rates of breast-feeding initiation, they experience significant stressors in sustaining the practice (Chesak, et al., 2021).

In looking at the relationship dynamic between primary care physicians and their patients with behavioral health needs, there is a similar gap between the demands of physicians at the individual level and the systemic constraints that make those demands increasingly difficult to meet. Systemically, time and access were consistent themes across the board, regardless of identified gender or specialty. Physicians reported the necessity of spending time with patients with behavioral health needs, often more time
than with patients who did not present with these needs. In addition, unlike referring their patients to other specialties such as cardiology or endocrinology, psychiatric referrals were increasingly difficult to make, as there were few providers in network with a patient’s insurance or more likely, there were extensive wait lists that prevented them from taking new patients. According to the physicians in this study, patients with behavioral health needs are not the problem. Rather, the structure of the medical system, which includes a lack of training in treating behavioral health issues, poor reimbursement rates for psychiatric care, and little access to behavioral health support, stymies physicians in their treatment of behavioral health issues at the primary care level.

The above is an important point to highlight in understanding the demands we place on our primary care physician workforce and the contribution that those demands make to physician burnout. As described above, this is particularly important for female identifying physicians, who experience differing patient expectations from their male identifying physician colleagues that are related to gender, including expectations for more empathic care, and increased time to discuss psychosocial issues (Linzer & Harwood, 2018). Most importantly, we know that physician burnout in general leads to negative patient care experiences, the increased likelihood of medical errors, and poor mental health outcomes for physicians (Chung et al., 2020; Shanafelt, et al., 2012, 2010).

Medical social workers have a role in advocating for and connecting physicians to resources for emotional and clinical support in treating patients with behavioral health needs. This could include hospital employee assistance programs (EAP), peer to peer mentoring programs, or consultation groups with behavioral health clinicians. It could include the development of resource lists, referral processes and strategies, providing
physicians with de-escalation training to manage crisis situations that come into their offices, or brief interventions to utilize in their practice. It could include advocacy on a systemic level, including supporting physicians in seeking longer visit times or more behavioral health resources for their patients, including advocacy surrounding integrated healthcare models. The findings of this study support having a medical social worker available in primary care, where behavioral health needs and social determinants of health are being identified and addressed in increasing numbers, and where physicians are overwhelmed, over worked, and under-resourced, especially women. It points to the need for medical social workers to understand the challenges of being a physician in primary care treating this population, and to view supporting this work as an essential part of social work practice in healthcare.

**Conclusion**

There is very little qualitative research exploring physician experiences. This could be for a variety of reasons, mostly likely due to a lack of time and availability, factors made scarce by the grueling schedule of seeing four patients an hour which most primary care physicians, working in large hospital and health networks, are asked to do. It could also be that we simply do not ask the following question enough: how are you managing? Physicians in this study were grateful to be heard, to be asked what they thought about the work they were doing, to have the forum to voice their opinions without fear of retribution.

The findings from this study help to give primary care physicians treating patients with behavioral health needs a voice. The study utilizes a novel methodology in which the richness of pen portraits are analyzed within the context of quantitative information.
on burnout, something that to my knowledge, has not be done before. Viewing the findings in this way enhances their dimensions, and provides further details that can inform interventions, such as identifying those on the borderline of burnout categories who may need further support. It is my sincere hope that as we listen to and encourage more primary care physician voices in healthcare research and develop more system-wide interventions, there will not be another primary care physician who feels obligated to come back to work, without adequate emotional resources, the day after losing a patient to suicide. With the right support from social workers and the greater healthcare system at large, I believe it is possible.
### Table 7

*Participant Themes by Burnout Profile*

<table>
<thead>
<tr>
<th>Profile Category</th>
<th>Gender and Specialty</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaged (High EE and PA, low DEP)</td>
<td>Bob, Joe, Thomas, Andrew, Charlene</td>
<td>More relationally based philosophies of care, strong awareness of boundaries and limits of their control, process oriented</td>
</tr>
<tr>
<td>Overextended (High EE)</td>
<td>Toby, Zaira, Sandra</td>
<td>Overwhelmed by lack of time to implement their BH training, acutely aware of ‘customer service’ aspect of job and the toll on physician wellness</td>
</tr>
<tr>
<td>Ineffective (Low DEP)</td>
<td>Teresa, Sarah, Cecelia</td>
<td>Overburdened with multiple tasks or roles, struggling to maintain existing scope of primary care practice with BH population, lack of support from or access to specialty mental health care</td>
</tr>
<tr>
<td>Burnout (High EE and DEP)</td>
<td>Jenny, Holly</td>
<td>A chronic feeling of unable to help patients with BH needs, giving freely of time with BH patients and getting bogged down with administrative tasks as a result, struggling to maintain work-life balance</td>
</tr>
</tbody>
</table>
Appendix A: Recruitment Script

Hello [NAME],

I am a doctoral student working on a research study for my dissertation entitled *Primary Care Physicians’ Experiences Treating Patients with Behavioral Health Needs*. I am looking to gain primary care physician perspectives on working with patients who have behavioral health needs. I am hoping that you might be able to assist me in sharing this information with the physicians in your practice and with recruiting some physicians to participate in the study. I have attached a flyer with more information. Participation would consist of completing a survey and conducting a 45–60-minute interview either virtually or in person. **Would you be able to forward this flyer to physicians in your practice?** I am also available to attend a provider meeting, virtually or in person, to **discuss the study further**. Please feel free to contact me at Ldennelly@brynmawr.edu if I can provide more information. I can also be reached by phone at 484-273-2974.

Thank you for your time,

Lauren Dennelly
Appendix B: Recruitment Flyer

Integrating Physical and Behavioral Healthcare in Primary Care: Primary Care Physician Perspectives Needed!

Are you a primary care physician working with adults in either a family medicine or internal medicine practice?

Do you treat patients with behavioral health needs in your practice setting?

Study participants will:
- Complete a brief survey on job related attitudes
- Complete a virtual or in person interview lasting 45 minutes to 1 hour
- Be entered into a raffle to receive a $25 Amazon gift card

If you are interested in participating or would like more information, please email Lauren Dennelly at ldennelly@brynmawr.edu OR Via phone at 484-273-2974.
Appendix C: Participant Screening Script

Hello [NAME],

Thank you for your interest in the study *Primary Care Physicians’ Experiences Treating Patients with Behavioral Health Needs*. I am interested in understanding the primary care physician experience working with patients with behavioral health needs. The study will involve participating in one interview about 45 minutes to 1 hour in length and well as completing a demographic survey and a brief survey on job-related attitudes. The interview can be scheduled via Zoom or in person at a time and place convenient to you. Your participation will be kept confidential. You will be entered into a raffle to win a $25 Amazon gift card.

At the time of the interview, I will ask that you sign an informed consent document. This informed consent document will explain the benefits and risks of participating in the research. Participation is entirely voluntary, and you may refuse participation at any time.

Do you have any questions so far?

Are you interested in participating in a screening to see if you are eligible to participate in the study?

*If no:* Do you have any specific concerns about participation that I could address?

*If still not interested:* Thank you for your time. If you have any additional questions I can be reached at Ldennelly@brynmawr.edu or by phone at 484-273-2974.

*If yes:* I would like to ask you the following two questions to confirm your eligibility for participation in the study:
1) Are you a primary care physician (MD or DO) working with adults in either a family medicine or internal medicine practice?

2) Do you treat patients with behavioral health needs in your practice setting?

3) Have you worked directly with this researcher in any professional capacity before?

**If ineligible:** I’m sorry but you are not eligible to participate. Thank you for your time.

**If eligible:** You are eligible to participate. I will email you the informed consent and we can either review it right now or schedule a day/time to review it. After reviewing and receiving your signed consent, we can schedule our interview. You will also be asked to complete a brief survey as part of your participation. What would be a good day/time to schedule a Zoom or in person meeting? If you have further questions, feel free to contact me at Ldennelly@brynmawr.edu or via phone at 484-273-2974.
Appendix D: Survey Script

You are receiving this email because you have agreed to participate in a qualitative study entitled *Primary Care Physicians’ Experiences Treating Patients with Behavioral Health Needs*. As part of your participation in this study, you were asked to complete a survey which includes basic demographic information as well as questions about job-related attitudes. This survey should take approximately 15 minutes to complete. You will receive this email again as a reminder if you have not already completed the survey. If you are unable to complete the survey, please inform the primary investigator at Ldennelly@brynmawr.edu.
Appendix E: Interview Consent Form

Title of research study: Primary Care Physicians’ Experiences Treating Patients with Behavioral Health Needs

Investigator: Lauren Dennelly, LCSW

Key Information: The following is a short summary of this study to help you decide whether or not to be a part of this study. More detailed information is listed later on in this form.

Why am I being invited to take part in a research study? You are invited to take part in a research study because you are a primary care physician who has worked with adult patients who have behavioral health needs.

What should I know about a research study?
- Someone will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you.
- You can ask all the questions you want before you decide.

Why is this research being done? This research is being done for the purposes of a doctoral dissertation exploring the lived experiences of primary care physicians who work with patients with behavioral health needs. Primary care physicians in particular have been disproportionately affected on the front lines of care by the increase in patients with behavioral health needs. This research aims to understand the implications of these patient-physician interactions on the patient-physician relationship. If social workers could better understand how primary care physicians work with and are affected by working with patients who have behavioral health needs, we could better support the primary care physician workforce and help mitigate the effects of physician burnout.

How long will the research last and what will I need to do? We expect that you will be in this research study for the duration of a 45-60 minute in person or virtual interview via Zoom in which only audio will be recorded. You will be asked questions about your experiences working with patients with behavioral health needs. You will also be asked to complete a brief survey gathering demographic information and information about job related attitudes.

More detailed information about the study procedures can be found under “What happens if I say yes, I want to be in this research?”
**Is there any way being in this study could be bad for me?**

Risks of participating are minimal and include potential breaches of privacy and confidentiality. Information you share will be kept strictly confidential. The primary investigator and a paid transcriptionist are the only people who will see the transcripts. Anything identifying will be removed, including geographic locations, names of particular individuals, or places mentioned. In the unlikely event that you find the interview is upsetting, I will provide referrals to professionals that can provide further assistance.

**Will being in this study help me in any way?**

There are no benefits to you from your taking part in this research. We cannot promise any benefits to others from your taking part in this research. However, you may find it interesting and helpful to talk about the issues addressed in the research and it may be beneficial to other primary care professionals with similar experiences.

**What happens if I do not want to be in this research?**

Participation in research is completely voluntary. You can decide to participate or not to participate, and you can end the study at any time.

**Detailed Information:** The following is more detailed information about this study in addition to the information listed above.

**Who can I talk to?**

This research has been reviewed and approved by [Name of Health Network] Institutional Review Board (“IRB”). You may talk to them if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get information or provide input about this research.

To contact the IRB:
Research Participant Protection Office
[Name, Address, and Phone Number of Health Network]

Both the Research Participant Protection Office and Lauren Dennelly can be reached Monday through Friday 9:00 a.m. to 4:30 p.m.

This research has also been reviewed and approved by Bryn Mawr College’s IRB for the purposes of a student dissertation. If you have questions, in addition to contacting the Principal Investigator, Lauren Dennelly (484-273-2974; Ldennelly@brynmawr.edu) you
may also contact the student’s supervisor, Sara Bressi (sbressi@brynmawr.edu) or Gary McDonogh, Professor and Chair, Bryn Mawr College IRB (gmcdonog@brynmawr.edu).

**How many people will be studied?**
We expect about ___20__ people here will be in this research study.

**What happens if I say yes, I want to be in this research?**
Participation involves an interview lasting approximately 45 minutes to 1 hour with a brief demographic survey as well as a survey on emotional health in professional practice, both of which should take about 15 minutes total.

**What happens if I say yes, but I change my mind later?**
You can notify the PI via email at Ldennelly@brynmawr.edu that you no longer want to participate in the research. You can leave the research at any time, it will not be held against you.

**What happens to the information collected for the research?**
The information collected for the research will be utilized for the purposes of a student dissertation. The data will not be used by [Name of Health Network] in any capacity outside of reporting results back to participants upon request.

**Confidentiality:** The collection and submission of study information will be accomplished with strict adherence to professional standards of confidentiality. Data will be de-identified beginning after the screening process in which eligible participants will be each be assigned a code. This code will be used for the duration of the study to identify the participant.

Information from this study may be published in social work journals, but your confidentiality will be respected and no names will be used in any report.

[Name of Health Network] Institutional Review Board may review any study generated data to assure compliance with federal regulations.

Please provide a phone number where you can be reached:

Providing your telephone number will assist the PI in contacting you after your interview should there be any clarifying questions needed for data accuracy.

**Can I be removed from the research without my OK?**
The person in charge of the research study can remove you from the research study without your approval if it becomes apparent that you do not meet study criteria.
What else do I need to know?
You can decide to drop out of this study at any time. Your participation is entirely voluntary.

There are no known or expected risks to you with your participation in this research study.

If you decide to participate, you will be asked to sign this consent below. If you are participating in your interview via Zoom, you will give this form to your practice manager, who will place it in a labeled envelope that will be marked with the research study name, the PI’s name and have ‘Confidential’ written on it. The person in charge of the research will receive the consent, sign it, and then provide you a copy.
### Signature Block for Capable Adult

Your signature documents your permission to take part in this research. You will receive a signed copy of this consent form.

<table>
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<tr>
<th>Printed Participant Name</th>
<th>Date (Mo/Day/Yr.) Time</th>
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<tr>
<th>Participant’s Signature</th>
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<table>
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<tr>
<th>Printed Name of Person Obtaining Consent (Must be Physician Investigator for drug and device trials)</th>
<th>Date (Mo/Day/Yr.)</th>
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Appendix F: Interview Protocol and Interview Guide

1. Protocol Name:
   • Primary Care Physicians’ Experiences Treating Patients with Behavioral Health Needs


3. Investigators:
   • Primary investigator (PI): Lauren Dennelly, LCSW; 484-273-2974
   • Faculty advisor: Sara Bressi, PhD, LSW, doctoral committee chair, Bryn Mawr Graduate School of Social Work and Social Research

4. Location of Study
   • Virtual interviews via Zoom or in person interviews at a location of the participant’s choice (pending COVID protocols) with physicians recruited from internal and family medicine practices in the [Name of City].

5. Background and Purpose

   Recent data suggests that 25% of health-related disability can be attributed to mental disorders (Kroenke & Unutzer, 2017). The treatment of behavioral health issues in medical settings, particularly primary care, represents a significant area of growth in research and practice in the healthcare field. People who experience depression often seek treatment in the primary care office rather than through a mental health agency (Borowsky et al., 2000), and the number of people who see their primary care physician rather than a psychiatrist for mental health care is increasing (Kroenke & Unutzer, 2017). Psychosocial and unexplained somatic symptoms consume a disproportionate amount of the primary care physician’s visit time (Curtis & Christian, 2012), and mental health conditions are often misdiagnosed or underdiagnosed, particularly in minority populations or in populations who frequently underreport symptoms (Borowsky et al., 2000). With the addition of the Patient Centered Medical Home model (PCMH) within the ACA, primary care is now required to encompass certain core tenets, including accessibility, comprehensiveness, coordination/integration, and sustained partnerships (Stange, et al., 2010). Fulfilling these requirements inevitably means working with patients with multiple chronic conditions including behavioral health needs.

   Though researchers have studied the impact of behavioral health integration in primary care on more tangible factors such as patient health outcomes and cost (Reiss-Brennan, et al 2010; Katon, et al., 2010; Syzmanski, Bohnert, Zivin, & McCarthy, 2012; Balasubramanian, et al 2017), there is a dearth of research that examines the impact on the patient-physician relationship, specifically eliciting the perspective of the physician. Amid the push for understanding the patient experience, it is important to ask physicians about their experience of the ongoing changes in healthcare and how this shapes their practice both globally and interpersonally. Few studies have examined the specific
relationship dynamics between primary care physicians and patients with behavioral health needs.

Examining the relationship between primary care physicians and patients with behavioral health needs is relevant given the emotional demands of working with psychiatric patients, particularly those with complex histories of trauma (Wampole & Bressi, 2019). It is common in medical treatment for providers to view these patients as demanding and emotionally draining, rather than lacking the interpersonal skills necessary to get their needs met. Stigma, particularly for those with substance abuse issues who are often perceived by healthcare providers as violent, manipulative, and lacking motivation, can place a strain on these interactions (Van Boekel, et al., 2013). Though there is a gap in this literature regarding behavioral health populations in a primary care setting, this research suggests that stigma can be a powerful force which shapes the healthcare interactions for patients with behavioral health issues and the providers that treat them.

Further, treating patients with multiple physical conditions in addition to one or more mental health conditions in a brief visit can be overwhelming for physicians, leaving them feeling ill equipped and frustrated. Emotional exhaustion, depersonalization, and reduced personal accomplishment can lead to feeling emotionally depleted in caring for patients, adopting a harsh or judgmental attitude towards patients, and feeling a sense of negativity about one’s performance and overall job satisfaction (Maslach, et al., 1996). Physician burnout has been found to contribute to poor patient outcomes, lower patient satisfaction, and a reduction in the primary care workforce (Bodenheimer & Pham, 2010; Halbesleben & Rathert, 2008; Ratanawongsa, et al., 2008).

Notably, a recent report headed by the Harvard T.H. Chan School of Public Health has reinforced the idea of physician burnout as a public health crisis, emphasizing the importance of addressing the mental health of the physician in ensuring the health and well-being of the public (Jha, et al., 2019). Systemic factors, including increasing expectations of primary care providers, the complexities of the electronic medical record (EMR), and a significant amount of time spent on administrative tasks including documentation, all act as contributors to provider burnout (Bodenheimer & Sinsky, 2014). Decreased autonomy, increased patient load, and the pressure to meet quality metrics also have a significant impact (Barnett, 2017). As physician burnout becomes a rising concern, it is important to examine what role treating increasing numbers of patients with behavioral health needs might play. Social workers working in integrated healthcare settings should be aware of the influence of burnout on the interpersonal dynamics between patients with behavioral health needs and primary care physicians and should be prepared to support colleagues in managing this population in order to help minimize physician burnout.

6. Study Aims/Objectives

The principle aim of the research is to understand the patient-provider relationship by exploring how the components of trust and collaboration inherent in the relationship between primary care physicians and their patients is shaped in unique ways with patients with behavioral health needs. Secondary to this, in understanding the physician experience in this way, social workers can further understand the implications for
provider burnout and for the role of social workers in assisting physicians in primary care settings with this population.

7. Research Questions

In this qualitative work, in lieu of hypotheses that may bias results, the following research questions will be investigated:

• How do primary care physicians describe the lived experience of treating patients with behavioral health needs?

• How does working with patients with behavioral health needs influence trust and collaboration within the patient-physician relationship?

• How do components of burnout, namely emotional exhaustion, depersonalization, and decreased efficacy shape the patient-physician relationship in integrated care?

8. Study Design

• What type of study will be performed?
  o A qualitative study in which the PI takes an interpretivist, partially phenomenological approach as a primary paradigmatic and methodological focus of inquiry.

• How will the study be conducted? Clearly outline design.
  o The PI will collect survey and demographic data which should take approximately 15 minutes. The PI will also conduct semi-structured interviews approximately 45-60 minutes in length. The survey data will include answers from the Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI-HSS MP; labeled as a survey of ‘job related attitudes’ as recommended by survey authors as well as demographic data including gender and whether the participant works in family or internal medicine. The PI will then utilize the pen portrait method of analysis (Sheard & Marsh, 2019; Spiers & Beresford, 2016; Holloway & Jefferson, 2013) creating narrative summaries across multiple data sources as a means of preserving the richness of participant experiences that is often lost when data becomes decontextualized. Participant portraits will include data from semi-structured interviews, the MBI-HSS MP and demographic information. Each portrait will offer a narrative experience of what it is like to treat patients with behavioral health needs in primary care and the skills needed to do so, explore aspects of the working alliance with these patients, and address the extent to which the participants report experiencing burnout.

• Specifically indicate primary and secondary endpoints.
  o N/A
• Indicate location of the proposed research. For example, the study will be conducted in [Name of Health Network].
  o The PI will recruit from [Name of Health Network] including, but not limited to, those outlined in Appendix B. The protocol document will not be modified each time a location is added, as the list is not exhaustive. Recruitment will be conducted by engaging gatekeepers, including but not limited to office practice managers, in assisting with access to physicians as well as articulating the benefit to their participation. Some strategies for this include contacting gatekeepers directly via phone, email, or attending provider meetings to discuss study (subject to COVID protocols) and providing a flyer with information on the study including the following information: inclusion criteria, area of focus, interviews will be completed virtually or in person at a location of the participant’s choice (subject to COVID protocols), participants will be asked to complete a brief survey, information will be confidential and participants will be entered into a raffle to win a $25 Amazon gift card.

• Indicate sample size of proposed study. Provide exact or estimate number of records that will be reviewed or patients who will be enrolled.
  o The primary investigator will conduct semi-structured interviews approximately 45-60 minutes in length (N=20). In aligning with the pen portrait method, the investigator will aim for a sample of at least 20 participants as a means of gaining sufficient depth with which to answer the research question or to otherwise reach a data saturation point. This number will need to be adjusted as data collection and analysis proceed simultaneously, or order to actively assess when this saturation point has been met.

• Clearly indicate all sources of data: electronic medical record (specify which EMR), database (specify), billing records, surveys, etc.
  o Semi-structured interviews
  o Burnout survey
  o Demographic data

• Designate time period that will be studied. For example, “the investigators will analyze all patients who were admitted to the medical service at [Name of Health Network] between January 1, 2006, and December 31, 2008.” Be specific. Remember: retrospective studies analyze data during a fixed period of time.
  o The data collection period is schedule to occur immediately following IRB approval (both academic and institutional) and is expected to take 6-7 months, including pilot interviewing, due to the current COVID-19 pandemic and physician availability.

• Need to clearly outline all data that will be analyzed.
  o Semi-structured interviews
  o Burnout survey
9. Inclusion and Exclusion Criteria

Inclusion criteria will be working as a primary care physician in either internal or family medicine with adults (18 and up) and treating patients with behavioral health needs. Exclusion criteria will be those who work as medical students, certified nurse practitioners, or physician assistants, those who work exclusively with patients under 18 years of age, those who do not treat behavioral health needs in their practice, and those physicians who have had a direct professional relationship with this researcher. To the PI’s knowledge, practices selected for sampling do not employ any physicians that the researcher has had a direct professional relationship with.

10. Analysis Plan

Construction of Pen Portraits and Thematic Analysis

Analysis will be ongoing throughout the interview process and will be iterative as new interview, burnout and demographic data is collected. The structure of the pen portraits will be adapted from Spiers and Beresford (2016) and will be organized utilizing the four key areas from the interview guide: physician experiences treating patients with behavioral health needs, the working alliance and components that influence it, professional skills required to treat patients with behavioral health needs, and the influence of job related attitudes on practice. Transcripts will be re-read and extensively examined for initial theme development. Next, each portrait will be constructed utilizing relevant quotes and summary points relating to each key area from the interview guide, from which further themes and subthemes will be developed. Then, these themes will be arranged visually to further examine the connections between them. Last, the researcher will engage in a thematic analysis of the data (Braun & Clarke, 2006) both within and across portraits, describing, refining, and condensing themes and identifying patterns in detail, until a sufficiently comprehensive and accurate account of participant experiences is produced. NVIVO 11 qualitative survey software will be utilized to aide in the data organization and analysis process.

Survey analysis

The PI will run descriptive statistics on the sample based upon the demographic and burnout measure. The MBI-HSS MP is divided into three subscales and measures burnout, depersonalization, and reduced personal achievement. Subscale scores will be calculated for the overall sample as well as for each individual. Participant profiles will be organized under the job-related attitudes area of the pen portraits and utilized to further describe participant experiences. For example, someone...
with an overextended profile is likely to score high in emotional exhaustion, while someone with a disengaged profile is likely to score high in depersonalization. The authors utilize standardized z values to calculate profiles within the following critical boundaries: high emotional exhaustion at \( z = \text{Mean} + (\text{SD} * 0.5) \); high depersonalization at \( z = \text{Mean} + (\text{SD} * 1.25) \); high personal achievement at \( z = \text{Mean} + (\text{SD} * 0.10) \) (Maslach, Jackson, Leiter, Schaufeli, & Schwab, 2019).

11. Risk/Benefits

- Risks of participating are minimal and include potential breaches of privacy and confidentiality. Information will be kept strictly confidential. The PI and a transcriptionist are the only people who will see the transcripts in full; the faculty advisor will only have access to segments of coded texts as part of advising the analysis of the data. Anything identifying will be removed, including geographic locations, names of individuals, or places mentioned. As an additional safeguard, should the participant find any of the material discussed to be distressing or if they require additional support outside of the interview setting, there will be a digital and/or hard copy list (depending upon the format of the interview) of behavioral health resources available for the participant.

12. Data Handling and Record Keeping

- Data in the form of voice-recorded interviews will be de-identified and protected according to the NIH Security Best Practices for Controlled-Access Data (NIH, 2015). If utilizing Zoom, it will have the iCloud backup feature turned off so that data does not get uploaded to the iCloud. An Excel spreadsheet containing the names of participants and their assigned codes will be named “Screening Codes” and stored on the PI’s U drive on [Name of Health Network] password protected computer. All files, memos, and coding notes will be de-identified using this code number; files including the interview data, transcribed audio file of the interview, and the interview transcript will be stored in a Word document on the PI’s U drive.

- The consent form will be completed with the PI prior to engaging in any research activities. If utilizing Zoom, the consent will be reviewed during a brief phone call. The participant will then sign the consent, and will be instructed to place the paper consent in a labeled envelope that will be marked with the research study name, the PI’s name and have ‘Confidential’ written on it, which will be kept in a designated private location in the participant’s work office (location to be secured prior to phone consent process with gatekeeper who will collect the consent from the participant and place in the folder for the PI to pick up). The PI will receive the consent, sign it, and then provide a copy to the participant.
Survey data will be exported from Qualtrics to an Excel spreadsheet named ‘Survey Data’ on the PI’s U drive. Documents will be stored in separate folders so as not to store audio files or transcripts in the same place as the “Screening Codes” or Consent forms, which will contain both names and codes. Backup print versions of all transcripts will be edited to exclude potentially identifying information and will then be stored in hard copy in a locked cabinet in the PI’s [Name of Health Network] work office, in case of widespread technological failure (NIH, 2015). None of the data can be used to identify the participants or tie them to their answers. All data will be saved for no more or less than a period of 6 years after the study has been closed with [Name of Health Network] IRB as per [Name of Health Network] policy. Regarding the security and storage of survey data, Qualtrics has provided the following information: https://www.qualtrics.com/support/survey-platform/getting-started/data-protection-privacy/ (Data protection and privacy) and https://www.qualtrics.com/security-statement/ (how data is secured).

Interviews via Zoom: Zoom allows the meeting host to select the location of the recording, including the cloud and a location on the host’s computer. As the Zoom meeting host, the PI will disable the cloud by selecting the documents folder on the PI’s U drive as the location for the recordings to save. The secondary recording (from SONY recorder) will be uploaded to a folder on the PI’s U drive called “Audio Files.” The PI will name the file according to the participant code (for example, it may be named “Audio007”). If interviews are conducted in person, a SONY recorder will be used as the primary recording device, with a second SONY recorder device as backup.

All audio files will be transcribed into Word documents and labeled according to the code (for example, “Transcript007”) and stored in a folder on the PI’s U drive called “Transcripts.” The audio files will be shared using the PI’s U drive, and the transcripts will be shared back to the PI using the U drive as well. The PI will read through the transcripts while playing the audio files to check for accuracy and edit the transcript files on the Word document. Transcripts will be edited to exclude all potentially over-identifying information that the participant may have mentioned in their interview, such as names or workplaces, which I will replace with “XXX.”

The edited transcripts are the only form of data that will be imported into the program NVIVO 11 for analysis. The PI is utilizing NVIVO 11 due to its user-friendly interface as well as its ability to integrate with Qualtrics if needed. NVIVO also does not collect details of data the PI is working with.
and has outlined this is their privacy policy (https://www.qsrinternational.com/privacy-policy, #6).

13. Funding
The project remains unfunded at this time. If funding is not secured, the PI will personally fund the cost of the licensing for the survey measure, a transcriptionist, and the gift card incentive cost. If funding is secured, it will be utilized to fund these costs.
Appendix G: Interview Guide

Relationships

Trust
1) How do you build rapport with these patients?
2) How do you talk to them about how their behavioral health information will be recorded in their record?
3) How do you make patients feel safe?
4) Are there times when you feel there is information missing from the patient’s account of the problem?

Collaboration
5) How do you engage in joint decision making with these patients?
6) What kinds of goals do you set with these patients?

Challenges
7) How do you manage tension or conflict if it occurs with these patients?
8) What do you do if there is a disagreement or misalignment of the patient’s goal for the visit and yours?
9) What is the biggest strain on the relationships you have with these patients?
10) Are there elements (resources, skill sets, patient characteristics, etc.) that are helpful to make interactions with these patients easier?

Specific Experiences
11) Any notable experiences with patients with behavioral health needs that you recall recently or within the past 6 months?
12) How did these experiences leave you feeling after you left the encounter?

Emotional Health
1) Describe one of your ‘worst’ professional days as of late.
2) Are there other professionals whom you can go to for support with behavioral health patients?
3) Are there times when you considered alternative careers or settings other than primary care?
4) Have you ever had one of your patients die by suicide?

Skills/Knowledge
1) How much behavioral health training did you receive?
2) How do you approach your interactions with these patients?
3) Are there times when you feel that you are practicing beyond your scope?
4) What do you do in these instances?
5) What is the single biggest challenge in working with these patients? The biggest reward?
Debriefing

1) Is there anything else I should know about your experiences treating these patients?
2) Is there anything else I could have asked to better understand your experience?
### Appendix H: Codebook

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>EXAMPLES</th>
</tr>
</thead>
</table>
| Behavioral Health Training and Experience | Physicians’ descriptions of their behavioral health training in medical school, residency, or on the job | • Acknowledging limited behavioral health training and limited scope  
• Recognizing the limits of ones skillset  
• Relying on training in integrated behavioral health  
• Utilizing brief therapeutic techniques in the encounter with behavioral health patients |
| Combating Burnout                         | Physicians’ descriptions of their experiences of their own burnout and the burnout of others, contributing factors and strategies for mitigation | • Acknowledging the importance of physician autonomy  
• Identifying the ‘business of medicine’ and burnout  
• Awareness of the burnout potential of self and others  
• Utilizing administrative time to effect systems level change |
| Making the job easier                     | Elements identified by physicians as helping to make the job worth doing and easier | • Acknowledging the rewards and successes in treating patients with behavioral health needs  
• Relying on the support of collaborative or interdisciplinary care  
• Using on site behavioral health support |
| Philosophies of care                      | Behavioral or relational treatment philosophies that guide physicians’ treatment of patients with behavioral health needs | Behavioral:  
• Expressing hesitancy about prescribing controlled medications  
• Learning to negotiate with behavioral regarding controlled mediations  
• Replying in protocol for treating behavioral health needs  
• Using a ‘tough love’ or more confrontational approach  
Relational:  
• Asking permission before discussing difficult topics  
• Developing a sense of emotional safety in the visit  
• Meeting patients ‘where they are’  
• Recognizing the value of listening to patients with behavioral health needs  
• Validating patient experiences  
• Using collaborative language |

135
| Physician emotional health and safety | Aspects of the job that impacted how physicians managed their emotions both within and outside of the encounter | • Managing difficult feelings including being ‘unable to help’ a patient  
• Managing patient expectations  
• Recognizing the limits of one’s control  
• Struggling with the concept of ‘do no harm’  
• Compartmentalization as a way of coping  
• Acknowledging a lack of formal debriefing support  

Safety:  
• Maintaining an awareness of safety procedures for threatening patients  
• Developing formal and informal strategies to protect clinician safety |
| --- | --- | --- |
| Putting the patient in charge | Physicians’ descriptions of how they keep the patient in charge of their visit while also collaborating with them | • Acknowledging and supporting patient autonomy  
• Finding out what’s important to the patient  
• Providing patient options for treatment as part of joint decision making |
| Systemic constraints | Agency or community elements that impacted physicians’ experience providing care to behavioral health patients | • Acknowledging the lack of access to psychiatry or other behavioral health support  
• Addressing poor communication between systems as a barrier to care  
• Awareness of structural changes needed to make integration successful  
• Recognizing social determinants of health in treating patients with behavioral health needs |
| Time | Physicians’ descriptions of the ways in which the element of time was a factor in relationship building | • Acknowledging the constraints and importance of time  
• Leveraging time in building relationships  
• Making an effort to maintain continuity of care with behavioral health patients |
### Appendix I: Glossary of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
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<tr>
<td>AMA</td>
<td>American Medical Association</td>
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<tr>
<td>BATHE</td>
<td>Background, Affect, Troubles, Handling of Situation, Empathic Response</td>
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<tr>
<td>BH</td>
<td>Behavioral Health</td>
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<tr>
<td>BMC</td>
<td>Behavioral Medicine Clinic</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<tr>
<td>DEP</td>
<td>Depersonalization</td>
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<td>EE</td>
<td>Emotional Exhaustion</td>
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<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
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<tr>
<td>MBI-HSS MP</td>
<td>Maslach Burnout Inventory Human Services Survey for Medical Personnel</td>
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<tr>
<td>PA</td>
<td>Personal Accomplishment</td>
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<tr>
<td>PC</td>
<td>Primary Care</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>PCP</td>
<td>Primary Care Physician</td>
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<td>PCMH</td>
<td>Patient Centered Medical Home</td>
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<tr>
<td>RVU</td>
<td>Relative Value Units</td>
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<tr>
<td>SSRI</td>
<td>Selective Serotonin Reuptake Inhibitor</td>
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<td>WHO</td>
<td>World Health Organization</td>
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(N.d.).