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Learning About Roger: A Supervision Case

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A behavioral health internship provides an unparalleled training experience for a Master's level clinical trainee. This narrative essay highlights how one behavioral health intern was pushed to the next developmental stage of learning as he encountered a patient with a complex medical condition and a new mental health diagnosis. This article also shares the learner's perspective on how both the patient and intentional systemic supervision fostered his professional growth.

KEYWORDS integrated healthcare, MFT training, systemic supervision

Behavioral Health Trainee

As a primary care behavioral health intern working in an integrated primary care setting, I learned valuable lessons about myself and the healthcare system. I learned that as a behavioral health provider (BHP) I had to possess both an investigative mind and make clinical decisions quickly and accurately. I had to learn new medical terms and start to understand the uses for common medications. I needed to acquire systemic understand of the roles and responsibilities of the other health care providers were and demonstrate my own contribution to the team. It is my strong belief that supervision was a salient component of my professional development. My supervisor became essential as I worked clinically with one patient, in particular, named Roger.

During my fourth month as an intern in an integrated primary care clinic, I met Roger. ***Roger self-identified as a 60-year-old Hispanic American male who was economically poor. He presented in clinic with well-tanned skin, long flowing white hair and a large bright smile. His extreme care in personal hygiene and matching clothes was a reflection of the expressed pride in his appearance. However, according to the medical assistant who roomed him, Roger was a homeless patient who seemed "very depressed" and demonstrated overt anger. From my observations, I saw a man with integrity who was deeply sad but full of personal integrity and strength.

Roger told me a story about his past. He mentioned that he was a musician and he and his wife built a comfortable life together before her death three years ago. Due to the loss of resources and subsequent depression, he lost all of his possessions except for his van and a trailer. Roger not only lost all of his family possessions but the comfort and secure attachment to his wife. I soon learned that he also was losing his identity and his health. As we talked, he expressed two significant concerns. The first was the new diagnosis of Hepatitis C. He talked openly about the stigma attached to this medical condition and strain of the subsequent treatment. The second was a fear of losing his identity and his passion for living life fully.

While the classroom prepared me with case studies, I did not feel prepared to develop an effective care plan for this patient. This sense of limited knowledge emphasizes the requirement

for an investigative mind and the influence of a supervisor who has experience in the area of integrated healthcare. Fortunately, I was able to find guidance and encouragement with my supervisor, Dr. Stratton. As I prepared for supervision that week, my goal was to be able to present Roger in a way that was concise and illuminative. I tried my best to use the model of precepting I had heard the medical residents use as they spoke about their own patients. I planned to present the patient from the RESPECTFUL model (D'Andrea and Daniels, 2001), expand upon my assessment, ask for specific support guidance and then examine evidence-based treatment modalities for a patient with his mental and physical symptoms.

I came to Dr. Stratton with the case. "Roger self-identifies as a 63-year-old homeless Hispanic American male. He did not endorse a history of alcohol or drug use. He cannot name anyone in this city who provides him emotional or financial support. He recently was told that he has chronic kidney disease stage 1 and elevated liver enzymes. Patient recently received the Hep C diagnosis after lab test indicated he had a positive HCV antibody (Ghany, Strader, Thomas, & Seef, 2009). He has symptoms of depression such as low mood, hopelessness, fatigue, guilty feelings and fleeting SI. He also has symptoms of anxiety such as chronic worry and negative cognitive ruminations. My observations include a hyperactive presentation including difficulty sitting without fidgeting. His language is demonstrative and his affect is bright. He was tearful throughout the visit. He appeared well nourished, had excellent hygiene and was dressed in casual but immaculate attire. He endorsed a chronic automatic thought that he is "worthlessness." He stated he was often neglected as a child. He grew up in 8 different foster homes. He considers the recent unexpected and premature death of his healthy wife as "traumatic."

Supervisor

As the clinical MFT supervisor, my role is to support my trainee in mastering behavioral health core competencies. Some of the essential skills include history taking, evaluation and assessment of mental health symptoms, conceptualizing the impact of physical health status, forming a differential diagnosis, developing an evidenced based treatment plan, and consulting with an interdisciplinary team. In order to supervise Randy effectively, it was important for me to acknowledge the developmental stage of his professional identity. Randy had only four months of clinical experience in a primary care setting. However, I also knew that Randy had been a patient with a major medical diagnosis of his own. While nascent as a clinician in this field, he was an expert on his own health care experience.

As a result of his stage of development, I chose to start by asking Randy questions. For example, what significance was the patient's ethnicity, his professional status as a musician, and his status as a single male? Did he screen for symptoms of a mood disorder? Did he determine the severity of the suicidal ideation (SI)? Is there a need to report the neglect from his childhood? Did he administer a clinical assessment for depression or anxiety? Does the patient currently take medication? If so, does he take it as prescribed? Did the patient see a therapist after his wife past away? If so, what was this experience like for him? What does the patient know about Hep C? How did he acquire it? What are the symptoms and what is the common treatment? Do the medications have side effects? I also asked Socratic questions to help support Randy's to learn to verbally conceptualize his patient from a biopsychosocial lens.

During the next supervision meeting, Randy decided he wanted to learn more about Hepatitis C. He learned that the associated stigma is related to an assumption that individuals

*** The identifying information of this patient was changed in order to maintain his anonymity

acquire it through IV drug use or risky sexual behaviors. Research is an ongoing process for all healthcare providers. Since the patient had denied any drug or alcohol use, we consulted uptodate.com for additional information and consulted with the medical team. We learned that there is a possibility that Hep C can be passed in utero and not discovered until later in life. We discussed that his depression had been untreated for several years. He learned that patients with the diagnosis of Hep C will often present as confused, fatigued, or/or depressed in the early progression of their illness and before anatomical evidence seen in the liver (Cellar et al., 2016). Therefore, Roger's affective symptoms of his disease may have hidden due to his significant losses. Randy wanted to learn how to use the PHQ-9 to track his symptoms from week to week to learn more about what was working in therapy. Randy needed to practice asking how the patient's suicidal ideation has changed since his wife passed away and what protective factors provided him hope.

Randy came to our next supervision with more information and some restlessness that he could not "do more" for the patient. I reassured Randy that he was providing support and care. However, Randy wanted to be even more helpful in improving the patient's mental and physical health. We discussed a targeted treatment plan. He and I vacillated between a focus on the patient's medication adherence and improving his sleep. Ultimately, we decided to focus on the adjustment to the medical diagnosis as this seemed to be the most prominent issue for Roger. His long trauma history would inform the intervention. His past experiences impacted his understanding of the medical diagnosis as well as the treatment for the symptoms.

Acceptance and commitment therapy (ACT) was selected as the treatment modality. As Batten (2011) describes there are three key elements about this modality that works well in the medical setting. First, the individual and the caregiver are experiencing difficult emotions based on health concerns. As a modality, ACT is very contextual and present minded. Furthermore, the model emphasizes the importance of clarifying values with the patient. In Roger's case, one of the ultimate challenges was helping him in clarify how his legacy with music was of great value to him and was essentially a reflection of who he is. This approach would potentially lessen his anxiety regarding his financial and occupational stress. Finally, ACT encourages the BHP to be the student as opposed to the expert, thus empowering the patient.

The intersectionality between the patient and Randy's identities was relevant right away. Randy's investment in helping this patient appeared to have urgency and associated anxiety. I was curious to learn more about this personal connection. The weekly supervision allowed us to discuss how the patient's similar age and own occupational struggles were bringing to light Randy's own urgency to be an effective clinician. In fact, Randy's decision to become a therapist developed in his fifth decade of life.

I learned a lot from Randy and from Roger. First, I learned that supervision is often a co-learning experience. We both needed to gain more education about a medical diagnosis, the medications that treat the symptoms and physical and mental impacts of both. I learned that I my own supervision inherently honors the knowledge of the person as clinician. Randy did care more about this patient. Self as therapist conversations and self-care was a central part of our supervision. When Randy could discuss his own pressure to "prove that pursuing a new career was not a mistake," he could free himself from perfection. Finally, Randy learned concrete skills that allowed to work competently within a medical setting.

*** The identifying information of this patient was changed in order to maintain his anonymity

Conclusion

Behavioral health training opportunities in medical settings are important for several reasons. First, it is imperative that mental health professionals train a workforce that can effectively collaborate with other health care professionals. This collaboration will allow a society to better advance population health. Increasing the work force will also improve access to BH health services, as patients are able to obtain mental healthcare along with their medical care. Finally, systemic, intentional supervision is an essential component of training as it provides the framework that illuminates the connectivity between healthcare issues and mental health.

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