VISTAS Online
ACA Knowledge Center
counseling.org/knowledge-center/vistas
703-823-9800 x281 | 800-347-6647 x281
By Drs. Garry R. Walz and Jeanne C. Bleuer of Counseling Outfitters, LLC | *Sponsored by the American Counseling Association*

Article 12

Bolstering Mental Wellness in the Medical Field: A New Role of Counselors

Annette Albrecht, Sharla Shaffer, and Beck Munsey

Albrecht, Annette, is a professor at Tarleton State University. Dr. Albrecht's current research involves the investigation of mental health issues within the career fields of various mental health and medical professionals.

Shaffer, Sharla, is a graduate student at Tarleton State University. Ms. Shaffer is currently enrolled in the clinical mental counseling program, and her research interests are related to the mental health of medical doctors.

Munsey, Beck (Rebecca), is an assistant professor at Tarleton State University. Dr. Munsey's research is in the area of social justice with an emphasis on investigating these issues within various populations.

Abstract

High rates of physician and medical student suicides occur yearly. Being in the medical field itself can be considered a risk factor for depression and suicide. Therefore, the medical field is beginning to seek an interdisciplinary approach to assisting helpers in need, and the counseling field can play an important role. Understanding the unique occupational stresses, hidden curriculum, stigma, and pressures these individuals face is crucial. Aiding this population also provides the opportunity to address the considerable incidence of medical errors attributed to physician depression and distress. Populations such as females and sexual minority individuals face additional challenges. Counselors are in a prime position to address physician suicide and depression, which helps improve patient safety. Proactively educating future medical students on the occupational stresses of burnout, depression, and suicidal ideation could prevent them from experiencing these conditions.

Keywords: physician depression, suicide, counseling, depression, medical school

For some individuals, entering the medical field is a known risk factor for mental health difficulties such as burnout, depression, suicidal ideation, or completed suicide (Dyrbye et al., 2008; Gold, Sen, & Schwenk, 2013; Legha, 2012; Wiegand, Bianchi, Quinn, Best, & Fotopoulos, 2015). Medical professionals encounter formidable occupational hazards such as increased mental health stigma, long work days, time spent on-call, and lack of autonomy (Nicola, McNeeley, & Bhargava, 2015; Wimsatt,

Schwenk, & Sen, 2015). A standard approach of reducing depression, burnout, and suicidal ideation in the medical field has not yet occurred, so field-wide improvement is absent (Eckleberry-Hunt & Lick, 2015; Legha, 2012). Consequently, some in the medical field are now seeking interdisciplinary assistance to stave off the high rates of psychological distress (Chang, Eddins-Folensbee, & Cloverdale, 2012; Chang, Eddins-Folensbee, Porter, & Cloverdale, 2013; Moutier et al., 2012). Counseling is among the professions capable of serving medical professionals who are in need of mental health services (Chang et al., 2013; Thompson, Goebert, & Takeshita, 2010). In fact, some professional counselors have already received referrals from the medical field, and other counselors could expect to have medical professionals as future clients (Mavis, Sousa, Lipscomb, & Rappley, 2014; Moutier et al., 2012; Thompson et al., 2010).

Anonymity can be crucial to the help-seeking behaviors of medical professionals (Adams, Lee, Pritchard, & White, 2010; Wimsatt et al., 2015). Some medical schools, such as the University of California, San Diego (UCSD) School of Medicine, have developed programs promoting mental wellness ("Erasing the Stigma," 2015). However, many medical professionals do not have access to a standardized mental wellness support system that is perceived to be beneficial (Benbassat, Baumal, Chan, & Nirel, 2011; Legha, 2012). Without adequate mental health treatment, patients in the care of medical professionals can become medical error statistics due to untreated or under-treated depression (Benbassat et al., 2011; S. K. Brooks, Chalder, & Gerada, 2011).

Since aspects of the medical profession's culture include occupational hazards, hidden curriculum, and stigma ("Erasing the Stigma," 2015; Ripp et al., 2015; Williams, 2016), counseling has been shown to be effective for medical professionals (Isaksson Ro et al., 2010; Zanardelli, Sim, Borges, & Roman, 2015). Medical professionals constitute a culture in which females and sexual and gender-variant individuals can endure additional adversities (Eliason, Dibble, & Robertson, 2011; Sansone & Sansone, 2009; Williams, 2016; Zanardelli et al., 2015). For the purposes of this paper, medical professionals are defined as medical students, residents, physicians, or surgeons.

Burnout, Depression, and Suicide in Medical Professionals

Burnout, depression, and suicide affect medical professionals at different rates than the general public (Dyrbye et al., 2008; Dyrbye et al., 2011; Eckleberry-Hunt & Lick, 2015; Genovese & Berek, 2016; Sansone & Sansone, 2009). Medical professionals are unlikely to be taking antidepressants and are at an increased risk for substance abuse, and those who commit suicide end their lives at a younger age than the general population (K. Brooks, Karp, Batlle, Chiu, & Montross, 2015; Eckleberry-Hunt & Lick, 2015; Nicola et al., 2015). It is likely that a combination of factors contribute to increased distress in medical professionals. Occupational stresses, the fear of seeking help, the stigma of having depression, and the hidden curriculum in the medical field can equate to deteriorating mental health (Adams, et al., 2010; Williams, 2016; Wimsatt et al., 2015).

Burnout

Adding to the mental distress of medical professionals, medical student mistreatment from other students or faculty occurs and can seriously affect the students' well-being later in life. Examples of injustices include sexual or verbal harassment,

discrimination, and mental or physical punishment (Cook, Arora, Rasinski, Curlin, & Yoon, 2014; Heru, Gagné, & Strong, 2009; Mavis et al., 2014). Possible consequences of maltreatment by faculty and other medical students are burnout and post-traumatic stress disorder (Cook et al., 2014; Heru et al., 2009).

Furthermore, medical professional burnout has been linked to medical errors, substance abuse, depression, and suicide (Benbassat et al., 2011; Nicola et al., 2015; Wurm et al., 2016). In 2008, Dyrbye et al. discovered that burnout in medical students was 49.6% at seven U.S. medical schools. Furthermore, Dyrbye et al. (2010) purported that 54% of students in five medical institutions who self-identified as "burned out" did in fact experience chronic burnout. Additionally, year-end prevalence of burnout in two different cohorts of internal medicine residents was reported to be 75% and 84% respectively by Ripp et al. (2015). Burnout is also prevalent in physicians. From 2011 to 2014, physician burnout was reported to increase from approximately 45.5% to 54.4% (Shanafelt et al., 2015). Similarly, Wurm et al. (2016) described self-reported prevalence of burnout in physicians at 50.7%.

Depression

Depression can alter brain function. Aggregate effects of depression are not clearly understood, but some widely recognized neuropsychological difficulties do exist (Snyder, 2013). Major depressive disorder impairs executive functioning such as planning, organization, impulse control, problem-solving, and overall work functioning (McClintock, Husain, Greer, & Cullum, 2010; Snyder, 2013). Depression is common among medical students, and, as a result, some have academic difficulties (Mellman & Paquette, 2012). Chang et al. (2012) noted in a medical student population that 60% disclosed experiencing depressive symptoms. Similarly, Adams et al. (2010) surveyed physicians and found that 46.2% reported suffering from at least one episode of depression.

Depression has been exposed as a major cause of physician suicide, yet many medical professionals fail to seek treatment (Dyrbye et al., 2008; Hendin et al., 2007; Wimsatt et al., 2015). Medical professionals often fear disclosing their depression. Their apprehensions include: (a) losing their medical licenses, (b) being passed over for a desired medical position, and (c) being seen by self and others as having a personal weakness (Adams et al., 2010; Chang et al., 2013; Gold et al., 2013; Wimsatt et al., 2015). Especially in the early stages of a first major depressive episode, individuals commonly delay seeking help. As a result, they can have reduced remission rates, worsened depressive symptoms, increased episodic recurrences, and a decreased response to antidepressants (Ghio, Gotelli, Marcenaro, Amore, & Natta, 2014). Untreated depressive symptoms can also attribute to decreased patient safety and reduced physician wellness (S. K. Brooks, Gerada, & Chalder, 2011; Weigl, Hornung, Petru, Glaser, & Angerer, 2012).

Suicide

Physician suicide statistics are staggering. In 2008, approximately 250 physicians took their own lives (Middleton, 2008). Recently, the suicide rate among American physicians has increased to at least one each day (Eckleberry-Hunt & Lick, 2015; Goldman, Shah, & Bernstein, 2015; Wible, 2014). Additionally, there is no way to factor

in the unknown number of suicides that occur due to deliberate misrepresentation on death certificates. Some physician death certificates may intentionally not list suicide as the cause of the fatality. The stigma associated with depression is expected to be one of the culprits (Gold et al., 2013).

Physicians are not the only medical professionals affected by suicide. At Baylor University's medical school, two students committed suicide within less than a year of each other (Chang et al., 2013). After the UCSD medical school lost a faculty physician to suicide, the death prompted the school to survey its student body, staff, and faculty. Among the respondents, 27% revealed being at a high risk for suicide, and 67% at a moderate risk (Moutier et al., 2012). Unfortunately, within a 6-year period, the UCSD School of Medicine lost six medical professionals to suicide ("Erasing the Stigma," 2015). At Stanford University recently, two of their medical school professionals took their own lives (Genovese & Berek, 2016). Further, during 4 years at the University of Michigan's medical school, 7.9% of fourth-year students reported having suicidal ideation, and 34.1% of first-year students thought that seeking help would make them feel less intelligent (Schwenk, Davis, & Wimsatt, 2010). Also, at the University of Hawaii's John A. Burns School of Medicine, 59.1% of the students reported depressive symptoms and 30.2% noted some suicidal ideation (Thompson et al., 2010). Rubin (2014) astutely noted that tracking suicides can be difficult due to some medical schools fearing being labeled as "suicide schools" (p. 1726).

Special Populations

Although any distressed medical professional is of concern to the medical field and to the general public, there are certain populations within the medical field that face greater risks. Two such populations are females and sexual minority individuals. In 2003, women comprised the majority of medical school applicants for the first time in history (Roskovensky, Grbic, & Matthew, 2012). According to Lapinski, Yost, Sexton, and LaBaere (2016), females were 1.5 times more likely than males to experience burnout. Furthermore, 77.7% of medical students surveyed by Lapinski et al. met a baseline level for depression. Due to the higher rates of burnout, females appear to be at an increased risk for depression. Higher depression and suicide rates of female medical professionals compared to their male counterparts are documented (Adams et al., 2010; Sansone & Sansone, 2009; Schwenk et al., 2010). Female physicians typically commit suicide earlier than do males (Gagné, Moamai, & Bourget, 2011). However, they are more likely to disclose suffering from an episode of depression, and they seek counseling at higher rates than males (Adams et al., 2010). Therefore, educating depressed female physicians about suicide is imperative.

The American Medical Association (AMA) and the Liaison Committee on Medical Education expounded on the importance of medical professional diversity. They have implemented standards to promote nondiscrimination in professional and medical student bodies (American Medical Association, n.d.; Liaison Committee on Medical Education, 2016). Lesbian, gay, bisexual, and asexual (LGBA) students assessed by Lapinski et al. (2016) were found to be 2.62 times more likely to experience burnout than their peers. Although 92.5% identified as heterosexual, of those identifying as LGBA,

62.5% met the study's criteria for burnout where only 38.85% of their peers met the same criteria (Lapinski et al., 2016).

In a comprehensive national study comparing medical students, Przedworski et al. (2015) found that 5% identified as either bisexual, homosexual, or other and thus were grouped as sexual minority students. Symptoms of depression were more common among the self-identified sexual minority individuals. Sexual minority medical professionals are also more likely to experience discrimination and hostile work environments. Eliason et al. (2011) cited practices "ranging from exclusionary employee and patient policies, lack of referrals from their colleagues, and witnessing derogatory remarks about LGBT individuals" (p. 1366). Mansh, Garcia, and Lunn (2015) disclosed that medical professionals who identify as sexual or gender minorities face abuse, harassment, exclusion from participating in clinical trials, and job discrimination. In a study including transgender female-to-male, male-to-female, and other conducted by Mansh, White, et al. (2015), 34% disclosed their identity in medical school and 60% chose not to identify with their gender status. Fear of discrimination by peers and faculty, as well as lack of support, were purported to be some of the reasons for nondisclosure.

Patient Safety: Do No Harm

In a profession that first and foremost upholds the requirement of doing no harm, patient harm is possible due to mental health issues such as depressed or suicidal medical professionals (Fahrenkopf et al., 2008; Garrouste-Orgeas et al., 2015; Hendin et al., 2007). Burnout itself has been linked to depression, and both potentially influence the quality of care or the amount of medical errors that patients experience (Lapinski et al., 2016; Nicola et al., 2015; Ripp et al., 2015). To improve patient safety and care, early mental health assistance for medical professionals experiencing difficulties is suggested (K. Brooks et al., 2015; S. K. Brooks, Chalder, et al., 2011). Individuals who enter the medical profession with altruistic motives may feel overwhelmed by obstacles such as: (a) medical bureaucracy, (b) high amounts of stress, (c) sleep deprivation, and (d) life-or-death situations. Maintaining balance and self-care can be critical for the medical professionals' psychosocial well-being and, ultimately, the patients in their care (Williams, 2016).

Depressive symptoms in medical professionals are identified as potential risk factors for medical errors. According to James (2013), between 210,000 and 400,000 yearly deaths occur in hospitals due to preventable errors. This does not include the approximate two to four million preventable errors that cause serious harm, but not death, to patients. Nor does the upper 400,000 limit include preventable serious harm or deaths by medical professionals outside of the hospital environment (James, 2013). For comparison, the number of documented cases of serious harm or death to patients ranges from more than the total population of the state of New Mexico to approximately the population of the state of Kentucky (U.S. Census Bureau, 2016). James called preventable patient harm an epidemic. Garrouste-Orgeas et al. (2015) posited that approximately 804 intensive care patients in a 1,000-day period endured medical errors. It is impossible to prevent all medical errors (James, 2013); however, addressing physician mental health could help prevent some of them (S. K. Brooks, Gerada, et al., 2011; Garrouste-Orgeas et al., 2015, Williams, 2016).

Stigma

As previously noted, medical professionals who experience mental health difficulties fear the associated stigma (Adams et al., 2010; Arboleda-Flórez & Stuart, 2012). Some patients feel as if they are not treated with the same respect as those without a mental health diagnosis. Most medical conditions are treated without the negative stigma that is attached to mental illness (Arboleda-Flórez & Stuart, 2012). As a result of the stigma, medical professionals typically do not seek help for their own challenges. For those who have had a prior episode of depression, the stigma of being identified as mentally ill is an enormous barrier to seeking help (Adams et al., 2010; Eckleberry-Hunt & Lick, 2015). One aggrieved physician wrote post-mortem to her physician friend who committed suicide: "Why didn't you ask for help? Why did you hide your depression? . . . I can still only speculate at the answers. I have no doubt, however, that we cannot continue to neglect the issue of physician suicide" (Middleton, 2008, p. 268).

Instead of being a part of the solution, medical professionals' attitudes toward depression are many times seen as part of the problem (Adams et al., 2010; Arboleda-Flórez & Stuart, 2012; Schwenk et al., 2010). In a survey of 1,256 medical professionals, Adams et al. (2010) reported that: (a) 46.2% responded affirmatively to having experienced at least one episode of depression, (b) almost two thirds feared they would let colleagues down, and (c) over 50% felt they would be disappointing their patients. Over 87% of the surveyed group perceived that medical professionals with depression were less likely to be appointed to a desired position (Adams et al., 2010). These types of perceived or real stigmas were the reasons for not seeking help.

Stigma has further-reaching internal consequences for medical professionals. Medical professionals have described the stigma associated with depression as something shameful that they should be able to control on their own ("Erasing the Stigma," 2015; Genovese & Berek, 2016). These medical professionals feel as though they need to not show signs of weakness and must be heroes (K. Brooks et al., 2015; Wimsatt et al., 2015). Distress is often seen by medical professionals as a personal failing rather than a reason to seek help (Legha, 2012; Middleton, 2008). Another result of the stigma associated with depression is the fear that a diagnosis of depression on their records could impact career progression and even the status of their medical licenses (Hendin et al., 2007; Zanardelli et al., 2015). Instead of seeking help, medical professionals may instead self-medicate with prescription drugs or alcohol to hide their mental health difficulties in an attempt to cope (S. K. Brooks, Gerada, et al., 2011; Eckleberry-Hunt & Lick, 2015; Marshall, 2008).

Occupational Stresses

Entering the medical field itself is a risk factor for death by suicide (Dyrbye et al., 2008; Legha, 2012). Legha (2012) purported that the fact that "a professional caregiver can fall ill and not receive adequate care and support, despite being surrounded by other caregivers, begs for a thoughtful assessment to determine why it happens at all" (p. 241). Factors that impact medical professionals include the ominous pressure of avoiding medical errors and malpractice litigation while working an average of 50–70 hours per week. Addressing medical professionals' occupational stressors and over-commitment is

important in the management of depression. The most prominent stressors include: (a) dealing with unreasonable patients, (b) needing to have good bedside manners, (c) being responsible for patients' health, life, and death, (d) handling long hours on-call, (e) fearing discrimination for reporting mental health difficulties, and (f) having feelings of low self-worth (Benbassat et al., 2011; Legha, 2012; Tomioka, Morita, Saeki, Okamoto, & Kurumatani, 2011). Due to long work hours, prolonged fatigue can ensue (Ruitenberg, Frings-Dresen, & Sluiter, 2012). Compounding that fatigue is that many physicians may average less than five hours of sleep a night (Wada et al., 2010).

Another important consideration is medicine's *hidden curriculum*, or the unofficial ideas and beliefs concerning the medical profession that medical students hear outside of the classroom (Williams, 2016). A few examples of hidden curriculum include accepting unethical conduct, disrespecting of co-workers, and not practicing in an evidence-based manner. Results of this hidden curriculum can include potential loss of integrity, as well as diminished moral and ethical values (Doja et al., 2016; Williams, 2016). These messages could be based on the discrepancies between what is taught in medical school and what is experienced in actual practice (Benbassat et al., 2011; Doja et al., 2016). Thus, the hidden curriculum may increase the emotional distress and burnout of medical professionals (Ripp et al., 2015).

These stresses can lead to relationship problems and drug or alcohol abuse, which can further compound problems associated with depression and suicide (Hendin et al., 2007; Marshall, 2008; Moutier et al., 2012; Zanardelli et al., 2015). According to Opinions 9.3.1 and 9.3.2 of the AMA's *Code of Medical Ethics*, medical professionals are said to be impaired when their wellness or health is compromised and could interfere with patient safety (AMA, 2016). During their medical careers, approximately one third of physicians will have impairment-related difficulties, and this includes alcohol and drugs (Pham & Pronovost, 2014). S. K. Brooks, Chalder, et al. (2011) reported that 38.5% of U.S. physicians developed a disorder related to substance use and 75.5% had a mental health difficulty.

A New Role for Counselors

Ethical codes encourage counselors to be advocates for those in need. Medical professionals constitute a group in need of mental health assistance (Przedworski et al., 2015; Sansone & Sansone, 2009; Wiegand et al., 2015). Counselors can help not only medical professionals as clients, but their patients as well. Helping to reduce mental distress of medical professionals would ultimately lead to increased patient well-being (Benbassat et al., 2011; Fahrenkopf et al., 2008; Weigl et al., 2012). Counseling is effective for mental health difficulties such as depression (Hagen, Wong-Wylie, & Pijl-Zieber, 2010; Hall, Jones, Tyson, Woods, & Keltz, 2016). Counseling interventions, such as mindfulness meditation, psychoeducation, wellness activities, hypnosis, and breathing exercises, reduce symptoms of depression (Hall et al., 2016). Advocating for the use of counseling inside and outside of the medical system may help moderate the amount of mental health difficulties and suicides in the medical community.

Some counselors and other mental health professionals have already achieved success at assisting this population. Isaksson Ro et al. (2010) purported that 184 physicians attended intensive individual or group counseling for job burnout. Examples

of interventions included psychoeducation, as well as cognitive, psychodynamic, and integrative therapies. The counseling interventions were focused on improving coping strategies pertaining to their roles and reducing stress at home and work. For those who completed the therapeutic interventions, physicians' emotional exhaustion and job-related stress were reduced, and emotion-focused skills related to coping were improved. Additionally, according to Thompson et al. (2010), depressive symptoms and suicidal ideation in students at the University of Hawaii John A. Burns School of Medicine were decreased with the implementation of counseling interventions by mental health professionals not linked to the students' medical educations. Other interventions leading to the improvement in the students' well-being included stigma reduction education, free or low-cost services from university or private practice counselors, classroom instruction about depression, and student handbooks describing wellness techniques (Thompson et al., 2010).

Various other medical schools and communities are actively trying to assist their medical professionals by providing mental health counseling. For example, the UCSD School of Medicine provides confidential university services and private outside counselor referrals to their students (Moutier et al., 2012). In an effort to reduce peer-to-peer medical professional maltreatment and sexual orientation, gender, physical, or verbal abuse, Mavis et al. (2014) suggested counseling intervention could be helpful. Adams et al. (2010) noted that only 34.9% of 1,256 responding physicians would seek counseling services if they suffered stress or strain. Therefore, stigma-reduction is a pivotal factor for medical professionals seeking help from mental health professionals (Eckleberry-Hunt & Lick, 2015; Schwenk et al., 2010; Zanardelli et al., 2015).

As noted, medical professionals often do not seek help (Gold et al., 2013; Mellman & Paquette, 2012). However, many in the medical community are now trying to find ways of improving medical professionals' resistance toward counseling. Yet fears of seeking help still abound. In a study of medical professionals at the University of New Mexico Health Sciences Center, some professionals personally sought help outside of the training institution, and the majority reported preferring to seek mental health care outside the center. Stigma and the fear of lack of confidentiality when obtaining counseling within the center were predominate concerns (Dunn, Moutier, Green Hammond, Lehrmann, & Roberts, 2008).

Counselors are in a prime position to assist both within and outside the medical community. According to the author of *Physician Suicide Letters - Answered* and the named 2015 Women Leader in Medicine, "Physicians should be offered confidential non-punitive mental health care on the job by trained mental health professionals" (P. Wible, MD, personal communication, June 21, 2016). Counselors are capable of serving these distraught individuals tasked with caring for the lives of all humans (Rubin, 2014; Thompson et al., 2010). With the knowledge of occupational stressors, stigma of depression, and high rates of suicidal ideation in the medical field, counselors are in a prime position to advocate for medical professionals at the individual, group, and societal levels.

A Case Illustration

The following case illustration depicts a hypothetical physician client (i.e., Client A) who eventually presented for counseling. Client A is a 42-year-old female primary

care physician. Although she had practiced medicine for the past six years with no serious mental health difficulties, during the past month she had lost two patients. One of the deceased patients was a 56 year old male who had complained of chest pain at a routine visit on a Friday. Client A performed the necessary preliminary tests, and his heart functioning was within normal ranges. At the conclusion of his appointment, Client A told the patient that if his chest pain continued, she wanted to see him as soon as possible. If his pain worsened, she explicitly expressed the importance of him immediately going to the emergency room. Client A was unaware that on the following Monday, the patient had tried to schedule a follow-up appointment and was unable to see her that day. He had failed to mention to her medical scheduler that his chest pain had escalated, so he was scheduled for later in the week to see Client A.

Later that Monday, Client A's patient suffered cardiac arrest while driving home on the freeway. Due to his cardiac arrest, he drove into the undercarriage of an 18-wheeler truck, causing the truck to veer into the next lane and crush a family of four. The patient and the family of four, including an infant girl and a four-year-old boy, died instantly. The truck driver suffered minor physical injuries. The patient's widow later mentioned to Client A that her husband was too cost-conscious to admit himself into the emergency room, and she could not convince him otherwise. Although Client A followed proper medical protocol during his initial exam, she was haunted by the thought of whether she should have allowed her patient to leave without questioning the likelihood of him going to the emergency room. In hindsight, she also regretted not ordering further tests.

Client A knew the risks of her job. They were made evident to her during her medical school training. She was taught to desensitize herself to death, but for unknown reasons this particular patient's situation still nagged at her. A self-described perfectionist, Client A had performed at the top of her high school class, as well as in her undergraduate biomedical engineering program and in medical school. Although she did experience self-described "anxiety and some depression" during medical school, she refrained from seeking assistance. At that time, Client A feared the stigma pertaining to a mental health diagnosis as a medical student. Due to the hidden curriculum in medical school, medical students knew they should be almost invincible and have no mental health difficulties. She perceived that receiving a mental health diagnosis could negatively impact her future employment. Although her self-described anxiety and depression "lingered a bit," she successfully completed medical school and started her professional career.

During medical school, Client A had a friend who hung himself after he became so sick from a burst appendix that he missed a final exam. Missing the final exam meant an automatic failure. It was his last year in school, he had been having marriage difficulties, and he had just failed his class due to a burst appendix. Client A later overheard a professor discussing her friend's suicide, stating that "he couldn't have handled it as a doctor anyway because he was mentally weak." This experience exasperated her fear of being perceived as mentally unfit; therefore, she never considered seeking mental health treatment while in medical school.

Due to her patient's death, Client A's untreated anxiety and depression from medical school escalated into "self-diagnosed clinical depression and generalized anxiety disorder." She was terrified of the seeing a counselor because of her fear of having a documented diagnosis in her medical records. Eventually, her declining mental state negative-

ly impacted her patients. Client A's nurse had to regularly call her to get out of bed to attend appointments. Client A mis-prescribed a potent medication to a patient, but the pharmacist caught the error. She was forgetting simple medical terminology. Concerned about being labeled as an unfit physician, Client A considered self-prescribing, but instead sought help from a trusted colleague. He prescribed the antidepressant Paroxetine. In order to keep her mental health difficulties secret, she got her medication filled at a pharmacy an hour away from where she worked. The Paroxetine caused significant weight gain for Client A, and her coworkers began suggesting she better lose weight because nobody wanted to take advice from an overweight doctor. She discontinued taking Paroxetine, her weight dropped, and she again became depressed and anxious. For a three day period, she called in "sick with pneumonia" because she was too depressed to get out of bed.

Client A's husband came home early on the third day to find her crying uncontrollably on the couch and saying that she had no reason to live. He pleaded with her to remember the effect it would have on their children and himself if she died. At this time, Client A's husband called her trusted colleague for help. The colleague referred Client A's husband to a counselor. At an appointment the next day, the counselor immediately worked with Client A on her suicidal ideation.

After her suicidal ideation had passed, Client A paid out-of-pocket for continued counseling sessions to address her anxiety and depression. After working with the counselor for a few months, Client A was able to return to her previous state of functioning. However, for fear of being medically sanctioned, she never told colleagues that she had received counseling.

Conclusion

Counselors who are aware of the specialized needs of medical professionals can assist with their mental health difficulties (Rubin, 2014; Thompson et al., 2010). Due to medical professionals' unique occupational stresses, hidden curriculum, and help-seeking stigma, they are often averse to seeking help (Benbassat et al., 2011; Legha, 2012; Tomioka et al., 2011). However, some medical professionals are seeking counseling assistance both inside and outside the medical community (Dunn et al., 2008; Isaksson Ro et al., 2010; Moutier et al., 2012).

Embedded within this culture are special populations comprised of females and sexual minority medical professionals. Females are more likely than their male counterparts to experience burnout, depression, and suicide (Adams et al., 2010; Lapinski et al., 2016, Sansone & Sansone, 2009; Schwenk et al., 2010). Sexual minority medical professionals experience higher rates of burnout and depression, as well as self-reported lower levels of health due to stress (Eliason et al., 2011; Lapinski et al., 2016; Przedworski et al., 2015). As more awareness about transgender individuals is coming to light, it will be important for future research to examine their experiences in the medical field (Mansh, Garcia, et al., 2015; Mansh, White, et al., 2015).

In order to help prevent the higher rates of medical errors due to untreated or undertreated mental health difficulties, such as depression, providing anonymous mental health assistance can be crucial (Benbassat et al., 2011; Dunn et al., 2008; Moutier et al., 2012). Mindfulness meditation, psychoeducation, hypnosis, and breathing exercises are

considered counseling practices that improve mental health (Hall et al., 2016). The medical community is beginning to refer medical professionals to mental health professionals. Advocacy by counselors for this underserved population could have immeasurable implications for medical professionals' mental health, and their patients would likely reap the benefits (Mavis et al., 2014; Moutier et al., 2012; Williams, 2016; Zanardelli et al., 2015).

References

Adams, E. M., Lee, A. J., Pritchard, C. W., & White, R. E. (2010). What stops us from healing the healers: A survey of help-seeking behavior, stigmatisation and depression within the medical field. *International Journal of Social Psychiatry*, *56*(4), 359–370. doi:10.1177/0020764008099123

American Medical Association. (n.d.). *AMA policies on LGBT issues*. Retrieved from http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page

American Medical Association. (2016). *Chapter 9: Opinions on professional self-regulation.* Retrieved from https://download.ama-assn.org/resources/doc/code-medical-ethics/code-2016-ch9.pdf

Arboleda-Flórez, J., & Stuart, H. (2012). From sin to science: Fighting the stigmatization of mental illnesses. *Canadian Journal of Psychiatry*, *57*(8), 457–463. doi:10.1177/070674371205700803

Benbassat, J., Baumal, R., Chan, S., & Nirel, N. (2011). Sources of distress during medical training and clinical practice: Suggestions for reducing their impact. *Medical Teacher*, *33*(6), 486–490. doi:10.3109/0142159X.2010.531156

Brooks, K., Karp, L., Batlle, H. R., Chiu, M., & Montross, C. (2015). A student collaboration to address mental health wellness in medical school. *Rhode Island Medical Journal*, *98*(7), 26–27. Retrieved from http://www.rimed.org

Brooks, S. K., Chalder, T., & Gerada, C. (2011). Doctors vulnerable to psychological distress and addictions: Treatment from the practitioner health programme. *Journal of Mental Health*, *20*(2), 157–164. doi:10.3109/09638237.2011.556168

Brooks, S. K., Gerada, C., & Chalder, T. (2011). Review of literature on the mental health of doctors: Are specialist services needed? *Journal of Mental Health*, *20*(2), 146-156. doi: 10.3109/09638237.2010.541300Chang, E., Eddins-Folensbee, F., & Cloverdale, J. (2012). Survey of the prevalence of burnout, stress, depression, and the use of supports by medical students at one school. *Academic Psychiatry*, *36*(3), 177–182. doi:10.1176/appi.ap.11040079

Chang, E., Eddins-Folensbee, F., Porter, B., & Cloverdale, J. (2013). Utilization of counseling services at one medical school. *Southern Medical Journal*, *106*(8), 449–453. doi:10.1097/SMJ.0b013e3182a05994

Cook, A., Arora, V., Rasinski, K., Curlin, F., & Yoon, J. (2014). The prevalence of medical student mistreatment and its association with burnout. *Academic Medicine*, *89*(5), 749–754. doi:10.1097/ACM.0000000000000204

Doja, A., Bould, M. D., Clarkin, C., Eady, K., Sutherland, S., & Writer, H. (2016). The hidden and informal curriculum across the continuum of training: A cross-sectional qualitative study. *Medical Teacher*, *38*(4), 410–418. doi:10.3109/0142159X.2015.1073241

Dunn, L. B., Moutier, C., Green Hammond, K. A., Lehrmann, J., & Roberts, L. W. (2008). Personal health care of residents: Preferences for care outside of the training institution. *Academic Psychiatry*, *32*(1), 20–30. doi:10.1176/appi.ap.32.1.20

Dyrbye, L. D., Harper, W., Durning, S. J., Moutier, C., Thomas, M. R., Massie, F. S., Jr., . . . Shanafelt, T. D. (2011). Patterns of distress in US medical students. *Medical Teacher*, *33*(10), 834–839. doi:10.3109/0142159X.2010.531158

Dyrbye, L. N., Power, D. V., Massie, F. S., Eacker, A., Harper, W., Thomas, M. R., . . . Shanafelt, T. D. (2010). Factors associated with resilience to and recovery from burnout: A prospective, multi-institutional study of US medical students. *Medical Education*, *44*(10), 1016–1026 doi:10.1111/j.1365-2923.2010.03754.x

Dyrbye, L. N., Thomas, M. R., Massie, F. S., Power, D. V., Eacker, A., Harper, W., & Shanafelt, T. D. (2008). Burnout and suicidal ideation among U.S. medical students. *Annals of Internal Medicine*, *149*(5), 334–341. doi:10.7326/0003-4819-149-5-200809020-00008

Eckleberry-Hunt, J., & Lick, D. (2015). Physician depression and suicide: A shared responsibility. *Teaching and Learning in Medicine*, *27*(3), 341–345. doi:10.1080/10401334.2015.1044751

Eliason, M. J., Dibble, S. L., & Robertson, P. A. (2011). Lesbian, gay, bisexual, and transgender (LGBT) physicians' experiences in the workplace. *Journal of Homosexuality*, *58*(10), 1355–1371. doi:10.1080/00918369.2011.614902

Erasing the stigma of physician depression. (2015, March 1). *Medical Staff Briefing*, *25*(3), 1–5.

Fahrenkopf, A. M., Sectish, T. C., Barger, L. K., Sharek, P. J., Lewin, D., Chiang, V. W., & . . . Landrigan, C. P. (2008). Rates of medication errors among depressed and burnt out residents: prospective cohort study. *British Medical Journal*, *336*(7642), 488–491. doi:10.1136/bmj.39469.763218.BE

Gagné, P., Moamai, J., & Bourget, D. (2011). Psychopathology and suicide among Quebec physicians: A nested case control study. *Depression Research & Treatment*, 2011, 1–6. doi:10.1155/2011/936327

Garrouste-Orgeas, M., Perrin, M., Soufir, L., Vesin, A., Blot, F., Maxime, V., . . . Timsit, J. (2015). The Iatroref study: Medical errors are associated with symptoms of depression in ICU staff but not burnout or safety culture. *Intensive Care Medicine*, *41*(2), 273–284. doi:10.1007/s00134-014-3601-4

Genovese, J. M., & Berek, J. S. (2016). Can arts and communication programs improve physician wellness and mitigate physician suicide? *Journal of Clinical Oncology*, *34*(15), 1820–1822. doi:10.1200/JCO.2015.65.1778

Ghio, L., Gotelli, S., Marcenaro, M., Amore, M., & Natta, W. (2014). Duration of untreated illness and outcomes in unipolar depression: A systematic review and meta-analysis. *Journal of Affective Disorders*, *15*(2), 45–51. doi:10.1016/j.jad.2013.10.002

Gold, K. J., Sen, A., & Schwenk, T. L. (2013). Details on suicide among US physicians: Data from the National Violent Death Reporting System. *General Hospital Psychiatry, 35*(1), 45–49. doi:10.1016/j.genhosppsych.2012.08.005

Goldman, M. L., Shah, R. N., & Bernstein, C. A. (2015). Depression and suicide among physician trainees: Recommendations for a national response. *JAMA Psychiatry, 72*(5), 411–412. doi:10.1001/jamapsychiatry.2014.3050

Hagen, B., Wong-Wylie, G., & Pijl-Zieber, E. (2010). Tablet or talk? A critical review of the literature comparing antidepressants and counseling for treatment of depression. *Journal of Mental Health Counseling, 32*(2), 102–124. doi:10.17744/mehc.32.2.al84578m4137768k

Hall, S. B., Jones, L. K., Tyson, L., Woods, K., & Keltz, A. (2016). The inflammatory hypothesis of depression: Implications for diagnosis and practice. *Journal of Mental Health Counseling, 38*(2), 124–138. doi:10.11744/mehc.38.2.04

Hendin, H. H., Reyonolds, C., Fox, D., Altchuler, S. I., Rodgers, P., Rothstein, M., . . . Thompson, J. N. (2007). Licensing and physician mental health: Problems and possibilities. *Journal of Medical Licensure and Discipline, 93*(2), 6–11. Retrieved from http://jmr.fsmb.org

Heru, A., Gagné, G., & Strong, D. (2009). Medical student mistreatment results in symptoms of posttraumatic stress. *Academic Psychiatry, 33*(4), 302–306. doi:10.1176/appi.ap.33.4.302

Isaksson Ro, K. E., Tyssen, R., Hoffart, A., Sexton, H., Aasland O. G., & Gude, T. (2010). A three-year cohort study of the relationships between coping, job stress and burnout after a counselling intervention for help-seeking physicians. *BMC Public Health, 10*, 213–225. doi:10.1186/1471-2458-10-213

James, J. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety, 9*(3), 122–128. doi:10.1097/PTS.0b013e3182948a69

Lapinski, J., Yost, M., Sexton, P., & LaBaere, R., II. (2016). Factors modifying burnout in osteopathic medical students. *Academic Psychiatry, 40*(1), 55–62. doi:10.1007/s40596-015-0375-0

Legha, R. K. (2012). A history of physician suicide in America. *Journal of Medical Humanities, 33*(4), 219–244. doi:10.1007/s10912-012-9182-8

Liaison Committee on Medical Education. (2016, March). *Functions and structure of a medical school: Standards for accreditation of medical education programs leading to the MD degree*. Retrieved from http://lcme.org/wp-content/uploads/filebase/standards/2017-18_Functions-and-Structure_2016-09-20.docx

Mansh, M., Garcia, G., & Lunn, M. R. (2015). From patients to providers: Changing the culture in medicine toward sexual and gender minorities. *Academic Medicine, 90*(5), 574–580. doi:10.1097/ACM.0000000000000656

Mansh, M., White, W., Gee-Tong, L., Lunn, M. R., Obedin-Maliver, J., Stewart, L., . . . Garcia, G. (2015). Sexual and gender minority identity disclosure during undergraduate medical education: "In the closet" in medical school. *Academic Medicine, 90*(5), 634–644. doi:10.1097/ACM.0000000000000657

Marshall, E. J. (2008). Doctors' health and fitness to practise: Treating addicted doctors. *Occupational Medicine, 58*, 334–340. doi:10.1093/occmed/kqn081

Mavis, B., Sousa, A., Lipscomb, W., & Rappley, M. (2014). Learning about medical student mistreatment from responses to the Medical School Graduation Questionnaire. *Academic Medicine*, *89*(5), 705–711. doi:10.1097/ACM.0000000000000199

McClintock, S. M., Husain, M. M., Greer, T. L., & Cullum, C. (2010). Association between depression severity and neurocognitive function in major depressive disorder: A review and synthesis. *Neuropsychology*, *24*(1), 9–34. doi:10.1037/a0017336

Mellman, L. A., & Paquette, B. (2012). Academic and career counseling for medical students and the complex role of the student affairs dean. *Academic Psychiatry*, *36*(3), 169–173. doi:10.1176/appi.ap.10020034

Middleton, J. L. (2008). Today I'm grieving a physician suicide. *Annals of Family Medicine, 6*(3), 267–269. doi:10.1370/afm.840

Moutier, C., Norcross, W., Jong, P., Norman, M., Kirby, B., McGuire, T., & Zisook, S. (2012). The suicide prevention and depression awareness program at the University of California, San Diego School of Medicine. *Academic Medicine: Journal of the Association of American Medical Colleges*, *87*(3), 320–326. doi:10.1097/ACM.0b013e31824451ad

Nicola, R., McNeeley, M. F., & Bhargava, P. (2015). Burnout in radiology. *Current Problems in Diagnostic Radiology*, *44*(5), 389–390. doi:10.1067/j.cpradiol.2015.04.007

Pham, J. C., & Pronovost, P. J. (2014). California's Proposition 46: A wolf in sheep's wool. *Annals of Internal Medicine, 161*(12), 913–915. doi:10.7326/M14-2167

Przedworski, J. M., Dovidio, J. F., Hardeman, R. R., Phelan, S. M., Burke, S. E., Ruben, M. A., . . . van Ryn, M. (2015). A comparison of the mental health and well-being of sexual minority and heterosexual first-year medical students: A report from the medical student CHANGE study. *Academic Medicine*, *90*(5), 652–659. doi:10.1097/ACM.0000000000000658

Roskovensky, L. B., Grbic, D., & Matthew, D. (2012). The changing gender composition of US medical school applicants and matriculants. *Analysis in Brief: Association of American Medical Colleges, 12*(1), 1–2. Retrieved from https://www.aamc.org/data/aib/archive

Ripp, J. A., Bellini, L., Fallar, R., Bazari, H., Katz, J. T., & Korenstein, D. (2015). The impact of duty hours restrictions on job burnout in internal medicine residents: A three-institution comparison study. *Academic Medicine*, *90*(4), 494–499. doi:10.1097/ACM.0000000000000641

Rubin, R. (2014). Recent suicides highlight need to address depression in medical students and residents. *JAMA*, *312*(17), 1725–1727. doi:10.1001/jama.2014.13505

Ruitenburg, M. M., Frings-Dresen, M., & Sluiter, J. K. (2012). The prevalence of common mental disorders among hospital physicians and their association with self-reported work ability: A cross-sectional study. *BMC Health Services Research, 12*, 292–298. doi:10.1186/1472-6963-12-292

Sansone, R. A., & Sansone, L. A. (2009). Physician suicide: A fleeting moment of despair. *Psychiatry*, *6*(1), 18–22. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2719447/

Schwenk, T. L., Davis, L., & Wimsatt, L. A. (2010). Depression, stigma, and suicidal ideation in medical students. *JAMA, 304*(11), 1181–1190. doi:10.1001/jama.2010.1300

Shanafelt, T. D., Hasan, O., Dyrbye, L. N., Sinsky, C., Satele, D., Sloan, J., & West, C. P. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedings, 90*(12), 1600–1613. doi:10.1016/j.mayocp.2015.08.023

Snyder, H. R. (2013). Major depressive disorder is associated with broad impairments on neuropsychological measures of executive function: A meta-Analysis and review. *Psychological Bulletin, 139*(1), 81–132. doi:10.1037/a0028727

Thompson, D., Goebert, D., & Takeshita, J. (2010). A program for reducing depressive symptoms and suicidal ideation in medical students. *Academic Medicine, 85*(10), 1635–1639. doi:10.1097/ACM.0b013e3181f0b49c

Tomioka, K. K, Morita, N. N., Saeki, K. K., Okamoto, N. N., & Kurumatani, N. N. (2011). Working hours, occupational stress and depression among physicians. *Occupational Medicine, 61*(3), 163–170. doi:10.1093/occmed/kqr004

U.S. Census Bureau, Population Division. (2016). *Annual estimates of the resident population: April 1, 2010 to July 1, 2015*. Retrieved from http://factfinder.census.gov/bkmk/table/1.0/en/PEP/2015/PEPANNRES/0400000US34.05000

Wada, K., Yoshikawa, T., Goto, T., Hirai, A., Matsushima, E., Nakashima, Y., . . . Hosaka, T. (2010). National survey of the association of depressive symptoms with the number of off duty and on-call, and sleep hours among physicians working in Japanese hospitals: A cross sectional study. *BMC Public Health, 10*, 127–132. doi:10.1186/1471-2458-10-127

Weigl, M., Hornung, S., Petru, R., Glaser, J., & Angerer, P. (2012). Depressive symptoms in junior doctors: A follow-up study on work-related determinants. *International Archives of Occupational & Environmental Health, 85*(5), 559–570. doi:10.1007/s00420-011-0706-8

Wible, P. (2014, October 26). Physician suicide 101: Secrets, lies, & solutions [Blog post]. Retrieved from http://www.idealmedicalcare.org/blog/physician-suicide-101-secrets-lies-solutions

Wiegand, S., Bianchi, W., Quinn, T. A., Best, M., & Fotopoulos, T. (2015). Osteopathic manipulative treatment for self-reported fatigue, stress, and depression in first-year osteopathic medical students. *The Journal of the American Osteopathic Association, 115*(2), 84–93. doi:10.7556/jaoa.2015.019Williams, D. (2016). Cracking the code on the "hidden curriculum" in the medical education pipeline and its contribution to attrition. *Journal of Unschooling & Alternative Learning, 10*(19) 82–99. Retrieved from https://jual.nipissingu.ca

Wimsatt, L. A., Schwenk, T. L., & Sen, A. (2015). Predictors of depression stigma in medical students: Potential targets for prevention and education. *American Journal of Preventive Medicine, 49*(5), 703–714. doi:10.1016/j.amepre.2015.03.021

Wurm, W., Vogel, K., Holl, A., Ebner, C., Bayer, D., Mörkl, S., . . . Hofmann, P. (2016). Depression-burnout overlap in physicians. *Plos ONE*, *11*(3), 1–15. doi:10.1371/journal.pone.0149913

Zanardelli, G., Sim, W., Borges, N., & Roman, B. (2015). Well-being in first year medical students. *Academic Psychiatry*, *39*(1), 31–36. doi:10.1007/s40596-014-0189-5

Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://www.counseling.org/knowledge-center/vistas