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## Portrait of a Novice Medical Family Therapist, Working in a Medical Setting with Head and Neck Cancer Patients Observed Through a Bowen Family Systems Theory's Lens

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Portrait of a Novice Medical Family Therapist, Working in a Medical Setting with Head  
and Neck Cancer Patients Observed Through a Bowen Family Systems Theory's Lens

by

Venetia L. Bennett

A Dissertation Presented to the

Dr. Kiran C. Patel College of Osteopathic Medicine

Nova Southeastern University

In Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

**Nova Southeastern University**

**2020**

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by

Venetia L. Bennett

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**Nova Southeastern University**  
**Dr. Kiran C. Patel College of Osteopathic Medicine**

This dissertation was submitted by Venetia Bennett under the direction of the chair of the dissertation committee listed below. It was submitted to the Dr. Kiran C. Patel College of Osteopathic Medicine and approved in partial fulfillment of the requirements for the degree of Philosophy in the Department of Family Therapy at Nova Southeastern University.

Approved:

November 20, 2020  
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December 18, 2020  
Date of Final Approval



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Christopher Burnett, Psy. D.  
Chair

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## Abstract

Each year, approximately 43,000 people in the United States, receive a diagnosis of cancer of the head and neck (American Cancer Society 2019). A diagnosis of cancer, regardless of its location can be overwhelming for patients, their caregivers, and their family system. Receiving such a diagnosis causes a reaction of heightened emotions and anxiety. With that, there is a growing need for medical family therapists. Medical family therapy has been documented as an effective approach for aiding medical providers to increase the quality of care for patients. Traditionally, medical family therapy is associated with general practitioners, pediatricians, and such medical environments. This autoethnographic study used the researcher's own personal journey as a mental health professional entering into the unique and challenging population of head and neck cancer (HNC). This research will be the first to explore the transition of a medical family therapist into the dental community. The purpose of this dissertation study was to understand the impact this challenging and unique population has on the student medical family therapist. The researcher examined the many relationships involved in the personal care of HNC patients as well as the professional care in the medical context of oral surgeons. It was through the application of Bowen's Family Systems Theory that the researcher was able to identify her own differentiation of self and triangulation entering such a different medical dynamic. The researcher reviewed her own interactions and experiences within the system of the patient, the resident surgeon, and faculty. The researcher evaluated this experience using Bowen's Family Systems Theory (BFST) lens. Applying the eight concepts of this theory, the researcher was able to work through her own personal challenges while managing the many relationships experienced in the



process within the context of a teaching institute in the field of HNC, as a student herself.

This study is based on the researcher's one-year clinical rotation with the Oral

Maxillofacial residents of Nova Southeastern University and attending faculty.

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## CHAPTER I: INTRODUCTION

“No man ever steps in the same river twice, for it's not the same river and he's not the same man.” From “On Nature” by Heraclitus of Ephesus

Just as you cannot step into the same river twice, no two journeys are alike, and no experience affects two people the same way. This work is based on my own journey as shaped by my own experience and worldview. My journey began long before I entered the field of marriage and family therapy (MFT), and at that time, I was not even aware of the journey that lay before me. While completing my undergraduate degree in business management, my program had almost come to a stop because the classes I needed to move forward were not going to be offered for more than nine months. The school I was attending offered me the opportunity to transfer to a different degree program to attend classes that would eventually transfer back into my program that would allow me to graduate earlier than scheduled.

It was while doing a homework assignment in my capstone class that I came to realize that this degree would serve as nothing more than a nicely framed piece of paper hanging on my wall. The assignment was to write about my past, prior to entering school, the present, my life while in school, and the future, how was I going to use my degree after graduation, including what organizations I was going to join. Not knowing exactly what I wanted to do, higher education began to take center stage. I always enjoyed presenting and teaching, but what would I teach and at what level? I knew that grade school was not an option, and teaching undergrad was not that appealing. I quickly realized I wanted to teach at a much higher level, and in order to do that I would need a

Ph.D. Now that I knew what I wanted to do, what subject did I want to teach? I always enjoyed psychology. Freud, Skinner, and Jung were all very interesting to me, but I knew there was more. I attended an open house at Nova Southeastern University that introduced me to a variety of programs. There I came to learn about the systemic world of MFT. Then and there I submitted my application for the master's program in marriage and family therapy. Despite the fact I returned to school later in life, my age was not going to deter me from my newfound desire to obtain my next degree or degrees.

As school progressed, I learned a lot about myself before I even began to learn who I could be as a therapist or what that even meant. What I did know was that I had found a world that I always knew existed but was never exposed to. I began to learn things that I wish I had known just months earlier as I watched the relationship my dying brother had with his wife. I took my mother to see him one last time before his passing. I was appalled at the way his wife would berate him with orders, more like demands, when she would visit. She would loudly and angrily tell him to get out of the hospital bed and go home before she would even enter his room, then climb into bed with him and watch a movie on his laptop. This behavior baffled me. Not long after classes started, I began to understand that my sister-in-law was not as nasty as my mind made her out to be. Rather this was her way of telling him she loved him and wanted him home. I always believed that when one family member gets sick, the whole family gets sick. Not literally, but the sickness affects everyone.

As I entered the second year of my master's degree and started exploring options of where I wanted to go next, my thoughts were all over the place. I even considered becoming a sex therapist, reviewing schools that offered such a degree. Not long before I

started working on my Ph.D., my mind was made up and I was on a path to dethrone the queen of sex therapy, Dr. Ruth. As my peers and I would discuss topics we would explore for our dissertations, my life turned to a new direction. Again, another homework assignment would steer me towards a new beginning, one that was strongly tied to my past that would lead me on this tireless, exciting journey.

The first year of the doctoral program we entered quantitative statistics. We were tasked with creating a quantitative mock proposal. The idea was for us to seriously think about our futures and chose a topic that would help mold us into our future selves. I had to really give this some serious thought. One of my oral maxillofacial residents, Jordan, stopped by my office and inquired how classes were going. As we talked, I mentioned the dilemma I found myself in for this mock proposal and not being able to fully embrace a topic that would assist me in dethroning Dr. Ruth. The very next day Jordan stopped by and placed an eight to ten-inch stack of research papers to peruse. As I looked through them, I saw a distinct theme with regard to Head and Neck Cancer (HNC) patients, their caregivers, and little discussion of mental health with regard to their condition. They talked about depression and disfigurement, but not about coping and how to face the world with a new face, or lack thereof. Often HNC is not detected early enough and patients go years before receiving such horrifying news. By this time, major surgery was typically the outcome. All these articles reminded me of something that happened at work a few years earlier when my boss was out of town.

The memory is vivid. I was working at my desk when one of the assistants came to me asking about the whereabouts of my boss for a patient. I walked through the door to find a man that was roughly a 6'5" with a fluffy teddy bear while tears filled his eyes. I



explained that my boss was out of town. His wife of 27 years had just learned that she had advanced HNC that went undetected for more than three years and was scheduled to lose half her face in seven days. I truly felt for this man and helplessly listened as he shared their story. I wanted to wrap my arms around him and give him a hug as I processed his words. Fortunately, I was able to identify two other maxillofacial prosthodontists at the university to refer him to and quickly introduced them. This incident played in my head often.

As I progressed in the master's program I would think back to this situation and come up with a million ways I could have done things differently. Breast cancer patients can get a mastectomy, wear a padded bra, and no-one would know the difference. My mother lived with a colostomy, she wore baggy clothes, and unless you were told about "Betty" you would never know what lied beneath her surface. Even amputees can easily camouflage their missing appendages. Losing half of your face? In my opinion, that is a massive change that requires a person to reach deeply into their own resiliency.

The words from these articles kept calling to me. While they were not all on the same topic, they all had to do with HNC and the negative impact it can have on an individual. With this, I began to gravitate toward this topic only to realize that the classes I was permitted to take out of my degree program in undergrad prepared me for this new adventure. I began to embrace the topic of this population and trying to identify how I could make a difference. During my master's program, I took additional classes that would provide me with a certificate in medical family therapy. To complete the program, I was required to do a one-year rotation in a medical facility working closely with doctors, residents, and their patients. I was permitted to complete this rotation at Broward

General Medical Center with Nova Southeastern University's Oral Maxillofacial Surgery (OMFS) residents, assistants, and attendings. As I successfully completed the program, I was halfway through my second year as a Ph.D. student. I felt prepared to tackle my topic from a qualitative stance. I love to learn from people. Hearing their stories, it was a perfect fit.

I was on a mission that no one could keep me from finishing. I made new friends in the doctoral program and we would work endlessly, hidden away from the world to make our dreams realities. We all knew that this task would not be an easy one, I was not prepared for the direction my life was going. Despite the fact that I often struggled with my research question, I never lost my passion for HNC patients and their caregivers. Even though I was very familiar with my topic, I still struggled to articulate it on paper. In addition, losing my father, losing my mother, and working through my own serious and frightening health challenges in the process did not help.

## **Background**

Life presented me with setback after setback. As mentioned, I experienced major health issues and lost both of my parents among many of the other distractions in the course of struggling to maintain a functioning and productive day-to-day life. I lost count of the times that I was not confident enough to continue with this daunting task. The loss of my mother, after being her caregiver for more than 26 years, left me with more bills and spare less time that needed to be filled, with efforts to earn enough money to keep moving forward. The last thing I could bring myself to focus on was my dissertation. My mission was slowly dismantling before my eyes and I struggled to keep it afloat. I reached out to my then Chair, not knowing how to ask for help, and her not knowing how

to help me. She suggested I speak with my other committee members for suggestions on how to take the next step in a direction where time was quickly diminishing.

From the beginning, the professors in the doctoral program continually encouraged me and my colleagues to “follow your passion.” The thought of changing topics was not an option for me as I felt the HNC population was deserving of recognition, and I continued to struggle to identify how could I make a difference. Would I be able to create a model that would help our growing university take the next step when it comes to caring for the HNC patient? Was this idea too premature as the hospital had barely broken ground? With that, the suggestion was offered that I write about my experiences during my one-year internship working closely with this population and those that served them: doctors, residents, dental assistants, patients, and their caregivers. Then, I was re-introduced to Autoethnography. According to Jones, Adams, and Ellis (2013), autoethnographers “choose to explore a particular aspect of themselves or their experiences” (p. 24). Getting back on track was not an easy task. Finding time to read and write while working two jobs was not going to be easy, but I was not going to give up.

### **Self of the Researcher**

For as far back as I can remember, I have believed in the notion that when one member of the family is ill, the entire family is ill. Working for the College of Dental Medicine, I have seen first-hand the devastating emotional and physical effects of cancer involving the head and neck. I became curious and fascinated about the patient’s process in dealing with HNC. In the quest to satisfy my curiosity and find some answers, I began to research the mental health effects of HNC on patients. One of the many things I learned is that often the caregivers of these patients suffered more than the patients

themselves (Badr, Gupta, Sikora, & Posner, 2014; Baghi, Wagenblast, Hambek, Radeloff, Gstoerrner, Scherzed, Spaenkuch, Yuan, Hornung, Strebhardt, & Knecht, 2007; O'Connor, 2007; Teschendorf et al., 2007). Further review identified that literature regarding quality of life focused more on validating the patient's quality of life through Likert Scale questionnaires, as well as close ended questionnaires where the patient was expected to choose from very generic answers (Deeken, Taylor, Mangan, Yabroff, & Ingham, 2003; Vickery et. Al, 2003; Brouwer et al., 2006; WHO, 2017).

I made a decision to complete a certification in Medical Family Therapy. According to Borrell-Carrió, Suchman, and Epstein (2004), "The late George Engel believed that to understand and respond adequately to patients suffering – and to give them a sense of being understood – clinicians must attend simultaneously to the biological, psychological, and social dimensions of illness" (p. 576). Medical family therapy gives therapists and researchers a systemic lens that encourages exploration beyond the family system by including a biopsychosocial component when illness is present. McDaniel, Doherty, and Hepworth (2014) believe "the fundamental assumption behind medical family therapy is that all health and relationship problems are biological, psychological, and social" (p. 5). Additionally, in the practice of medical family therapy, the therapists not only consider the many aspects of one's mental/medical health, which includes the many medical professionals involved in the journey to improved health (McDaniel, Hepworth, & Doherty, 1992). McDaniel et al. (2014) remind us that this model considers the notion that "psychosocial issues" go hand-in-hand with "biological features," because one cannot be present without the other (p. 5). What is not represented in the literature is what effect the impact of entering such an environment might have on

a novice medical family therapist. How does one enter this field while manage their own anxieties when faced with such a unique and challenging population?

While completing my certificate in Medical Family Therapy, I completed a one-year internship at a local hospital with the OMFS residents from Nova Southeastern University. I participated with both facial trauma cases and HNC cases. I came to realize that the anxiety and major life changes were not always expressed only by the patients themselves, but also by the caregiver. Initially I presumed the caregiver would be someone who is medically trained and paid for such services, however, more often than not, the patient's spouse or partner or someone else from the patient's core support system was the caregiver. I learned that the caregiver population includes, but is not limited to a patients' siblings, children, friends, parents, neighbors, and even members of his or her chosen place of worship.

As I gained more access to the interaction between the HNC patients, their caregivers who often accompanied them to treatments, and the professionals who provided medical services, I discovered another psychological aspect. This discovery has added another layer to my interest, my curiosity, and my own compassion for all involved. I realized that the medical providers, including any mental health professional, also have to struggle with the impact of seeing a severely deformed face of a patient. If I intended to immerse myself in this field, I had to recognize that the psychological aspects of the physical manifestations of HNC are deeper and more complex than those of most other cancers. This realization helped me to become as sensitive and as attuned to the medical staff's needs as I have been to patients and their caregivers.

Initially, the residents and attending faculty were not sure what to hypothesize about my presence there. They would forget to include me when entering rooms. I needed to immerse myself in their process. An opportunity that allowed me to enter the rooms with them and take in everything as it unfolded before me. I took in every word they said and every day before I left, I met with those I could, to better understand their process, especially how they would communicate the next phases of treatment with the patient and any family or caregivers in attendance at the appointments. I would also ask general questions about HNC patients and their family systems.

I wanted to learn their language. I wished to identify a way I could become useful to everyone: patients, caregivers, residents, and even the attendings. I wanted to know their thoughts on these cases, regardless of the patient's age or status. To do this, I felt I needed to roll up my sleeves and become a part of their process. When it was really busy, I would help the dental assistants clean up the rooms and sanitize them for the next patient. It wasn't long before the residents would look for me to enter a room with them for such appointments. I felt like I was finally part of the team. I was there to do whatever needed to be done to involve myself with this population. What I did not anticipate was the untimely death of my father in the process. With this new challenge of my own, how was I going to manage my own anxieties throughout this process? To do this, I chose to apply Bowen's theoretical concepts that are driven by one's differentiation of self.

As the residents became more comfortable with my presence in the clinic, they began to include me in conversations in the room. They would introduce me to the patients and their families. They even began to notice that patients started to appear more at ease with difficult conversations when I was there. I am confident that it was not my

presence alone, but rather the patients possibly noticing that their care extended beyond the voices of the medical team. There was someone there that would stay behind when the doctors left the room and would listen to them.

### **Purpose of the Study**

I chose to conduct an autoethnographic study as I believe my experiences provided the closest perspective, from a Bowenian Family Systems Theory (BFST) lens, with regard to the interpersonal relationships of head and neck cancer patients and their providers of care.

The goal of this study was for me to use my own personal journey as a mental health professional entering into the challenging and unique population of HNC patients. I examined the many relationships involved in the personal and professional care of the patients. I reviewed the interactions and experiences within the systems of the patient, the residents, and faculty, applying Bowen's *Family Systems Theory*. This study is based on my one-year clinical rotation with the Oral Maxillofacial residents of Nova Southeastern University and attending faculty. I hope my work creates new opportunities for therapists and researchers alike to help advance their experiences and bring new hope to those who need it most wherever they are on their journey.

While most studies are known for explicitly stating a research question (Creswell & Poth, 2018), this study sought to understand two issues. Using the connection with this population and my doctoral work, I asked myself these questions: (a) what did I learn about my own differentiation of self, navigating through the many triangles, while managing my own anxiety as a novice medical family therapist from my one-year

internship with our Oral Maxillofacial faculty and residents? (b) how can MFT's and other practitioners better prepare for entering such a unique and challenging population?

### **Significance of the Study**

To the best of my knowledge, this study is the first to explore a novice medical family therapist entering the challenging and unique population of HNC. Through the use of BFST, I was able to reflect upon my own experience with my own anxiety. Findings of this study provide valuable insight into what it is like to be a novice MedFT working in a completely different environment from standard general practitioners and specialists, including both the positive and negative challenges that I encountered.

### **Research Design**

Given the nature of an autoethnographic study, I positioned myself as the sole participant in this study. After gaining approval from Nova Southeastern University's Institutional Review Board (IRB approval #2020-420), data was collected through the retrieval of Chang's (2016) personal memory and self-reflective data, which was enhanced by the use of an autobiographical timeline, inventory of self, and the use of proverbs. The data was refined through the identification of exceptional occurrences and analyzed through the context of BFST by applying the eight concepts while reflecting upon my own experiences.

### **Assumptions and Limitations**

This study is limited to my perceived interpretation of my personal experiences with my own anxiety. I relied on the use of Bowen's Differentiation of Self scale, reflecting on my own differentiation of Self while applying Titelman and Reed's (2019) *Variation in Differentiation and Family Reaction to Death* (p. 31), which reviews the



eight basic concepts from varying levels of a lower-level differentiation versus a higher-level of differentiation. Additionally, based on my self-reflective premise of autoethnographic writing, the findings of this study are reflective of my personal assumptions regarding differentiation of self, which may vary from that of other medical family therapists.

### **Overview of the Chapters**

Chapter Two provides a basic overview of cancer along with some of the more common HNC diagnoses. I include some factors that may impact the HNC patient, including but not limited to the Internet, risk factors, and the social stigma of facial deformity. I briefly mention aspects of illness and caregiving. I describe Engle's biopsychosocial approach that lead to Medical Family Therapy as we have come to understand it. Lastly, a review is provided of BFST and how his 1977 theoretical framework could be of assistance in the area of medical family therapy crossing over into more unique and complicating modalities such as OMFS.

Chapter Three describes my research methodology and analytic writing method for my study. I focus on the qualitative research methodology proposed for use in this study. I explain autoethnography as a form of qualitative inquiry and describe the data collection process. Additionally, I provide a step-by-step plan for how the research study was executed. I also give a detailed explanation of the data analysis process and information related to how I went about conducting trustworthy research.

In Chapter Four, I discuss the results from the memory data collection process and how BFST was used to help me navigate through this process. Lastly, in Chapter Five I discuss the implications for further research and trainings needed to educate future

medical family therapists in order for them to expand beyond traditional medical family therapy into more challenging applications.

## **CHAPTER II: REVIEW OF THE LITERATURE**

“Systems thinking... is directed at getting beyond cause-and-effect thinking and into a systems view of the human phenomenon. Emotional reactivity in a family, or other group that lives or works together, goes from one family member to another in a chain of reaction pattern.” Murray Bowen, 1973

Cancer knows no boundaries, often appearing with little warning, sometimes creeping in slowly while other times moving quickly with little time to prepare. The effects of cancer are unique to each individual patient. Those effects are often easily concealed depending on the type of cancer involved. For example, a woman with breast cancer can have a double mastectomy, wear a padded bra and to the outside world, she seems physically whole. Those affected by colorectal cancer, when there is a need for a partial or full colectomy that results in a colostomy, the individual can wear baggy clothes that help camouflage the condition. Even amputees have special prosthetic limbs that allow them to function and appear “normal.” In contrast, when one loses half of a face due to a surgical procedure from the effects of HNC, the physical effects, both on the patient and on those interacting with the patient, are severe and very visible. Sadly, society places major importance on esthetics. For patients with HNC, the psychological and emotional consequences of facial disfigurement are huge and not easily overcome. The anxiety of such diseases not only impacts that of the individual, but also that of their family and caregiver system.

The literature outlined in this chapter shows a major emphasis on the HNC patient, their caregiver(s), and the relationships with one small piece of their medical

teams through my own observations while completing a one-year clinical rotation with a team of oral maxillofacial residents and attending faculty. I will identify some basic history of cancer and its progression, with a concentration on some of the more commonly known HNC diagnosis. A brief review of the literature regarding cancer patients, more specifically, the HNC patient, the caregiver, and his/her relationship with the caregiver through a BFST lens. I will further investigate the relationships between the HNC patient and the caregiver system using the eight basic concepts of Bowen and review the different levels of such relationships amongst the literature within the realm of Medical Family Therapy and the relationship outcomes, as experienced during my clinical rotation.

## **Cancer**

Each year, more than 1.6 million people in the United States receive a diagnosis of cancer (ACS, 2019; NCI, 2019). Receiving a diagnosis of cancer in and of itself is frightening, even overwhelming for individuals, as well as their families (Vickery, Latchford, Hewison, Bellew, & Feber, 2003; Grunfeld, Coyle, Whelan, Clinch et al., 2004; Röig, Hirsch, & Holmström, 2008; Tobin & Begley 2008). Now, envision that the area of concern involves one's head or neck and requires major oral maxillofacial surgery (OMFS), as a result of the diagnosis. More than 60,000 U.S. residents are diagnosed with cancer of the head and neck each year; sadly, that number is steadily growing (ACS, 2019; NCI, 2019).

The National Cancer Institute believes that more than 100 diseases are considered cancer or of a cancerous nature (NCI, 2019). While not every cancer is life threatening, when left untreated, any cancer is capable of spreading rapidly throughout the body

developing into serious chronic condition (ACS, 2019; NCI, 2019). Cancer can afflict anyone, regardless of race or age, and requires specialized medical care and/or services outside of the norm. This is true for any of the hundreds of diseases associated with cancer. The cancer patient may be a newborn baby, a 16-year-old who just passed a driving test, a new father whose partner just gave birth to a healthy child, or an 80-year-old grandmother who just celebrated her 50th wedding anniversary to her high school sweetheart (ACS, 2019; NCI, 2019). Some patients are lucky and respond well to minimal treatment while others are not so fortunate and have to undergo serious and painful treatment. Such treatments might include surgery, whether partial or full, removal of the mandibular bone, the tongue, or other portions of the facial anatomy depending on the severity and location of the diagnosis. Just the thought of it, let alone the act of it, has the potential to bring trauma.

The American Cancer Society (2019) and the National Cancer Institute (2019) describe cancer as a multitude of diseases wherein abnormal cells in the body reproduce at a very rapid rate. Typically, when cells die our bodies naturally flush them out. However, when this does not happen, the new regenerating cells have the ability to negatively impact a cell's deoxyribonucleic acid (DNA). If the DNA is not restored to its original form and the cells do not die, as they should, there is a possibility that the cells will continue to generate more DNA modified cells that may be harmful to the body in which they reside and cause disease to be born. More than 100 diseases are classified as cancer, resulting in nearly 600,000 deaths per year (ACS; NCI).

There are more than 8,000 terms used to describe cancer and medicine associated with it (NCI). Usually cancers are named after the organ in the body where they

originated (ACS; NCI). The Institute of Medicine (IOM, 2008) identified, “The diseases that make up cancer represent both acute life-threatening illnesses and serious chronic conditions” (p. 2). Even though it has been determined that not all cancer is considered terminal, when left untreated it is capable of advancing into a severe illness that could be life threatening (ACS; NCI). Once a cancer cell enters the bloodstream, it manipulates the patterns of normal/healthy cells and spreads through a process commonly referred to as metastasis. These abnormal cells travel through the human lymphatic system, intensifying the disease and becoming more detrimental to the body (ACS; NCI).

Great strides have been made in the diagnosis and treatment of cancer over the last couple of decades thanks in part to the many organizations that have gotten together to work towards a better tomorrow for the cancer patients and their families. The Institute of Medicine (2008) suggested:

Early detection and improved treatments for many different types of cancer have changed our understanding of this group of illnesses, from that of a single disease that was often uniformly fatal in a matter of weeks or months to that of a variety of diseases – some of which are curable, all of which are treatable, and for many of which long-term disease-free survival is possible.

### **Head and Neck Cancer**

Cancers that metastasize within the head and neck region, regardless of where they first appear, whether in the nose, inside the mouth, or even the throat “begin in the squamous cells that line the moist, mucosal surfaces inside the head and neck” (NCI, 2019). Inclusive in this zone is also the aerodigestive tract, which also consist of the lips, mouth, tongue, nose, vocal cords, the esophagus, and windpipe (NCI, 2019). Our bodies

have two primary internal membranes; the mucous and the serous membranes. Saladin (2018) describes mucosa as “a tissue layer that forms the inner lining of an anatomical tract that is open to the exterior (the respiratory, digestive, urinary, and reproductive tracts). Composed of epithelium, connective tissue and often smooth muscle” (p. G-13).

Aside from the standard secretory and absorptive features of the mucous membranes, they also provide protective functions (Saladin, 2018, p. 165). As with all cancers, when the cells within the mucosal surface are compromised the cancer (benign or malignant) takes on its course. According to Wittekindt, Wagner, Mayer, and Klusmann (2012) “Head and Neck Squamous Cell Carcinomas (HNSCC) are the 6<sup>th</sup> most common cancers worldwide” (p. 1). The “most common” areas are outlined in figure 1.1 (NCI, 2017).

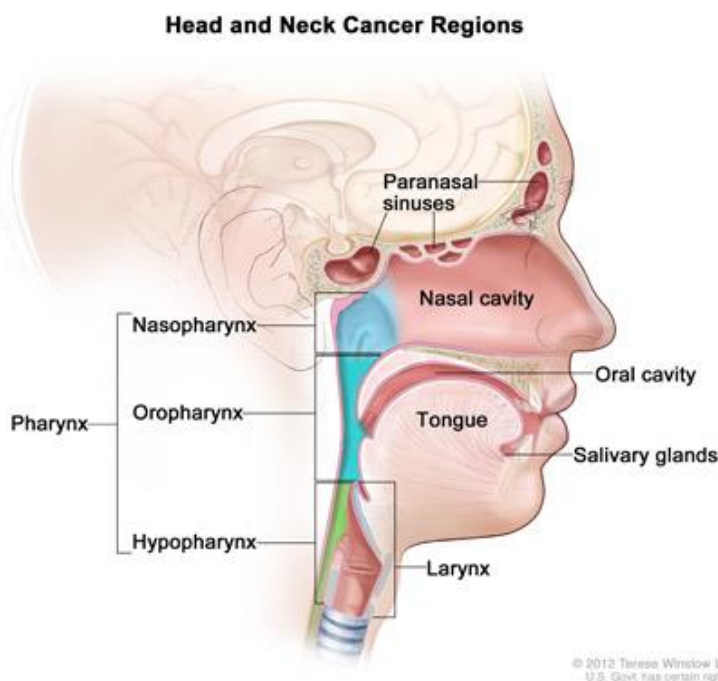


Figure 1.1 Head and Neck Cancer Regions (NCI, 2017).

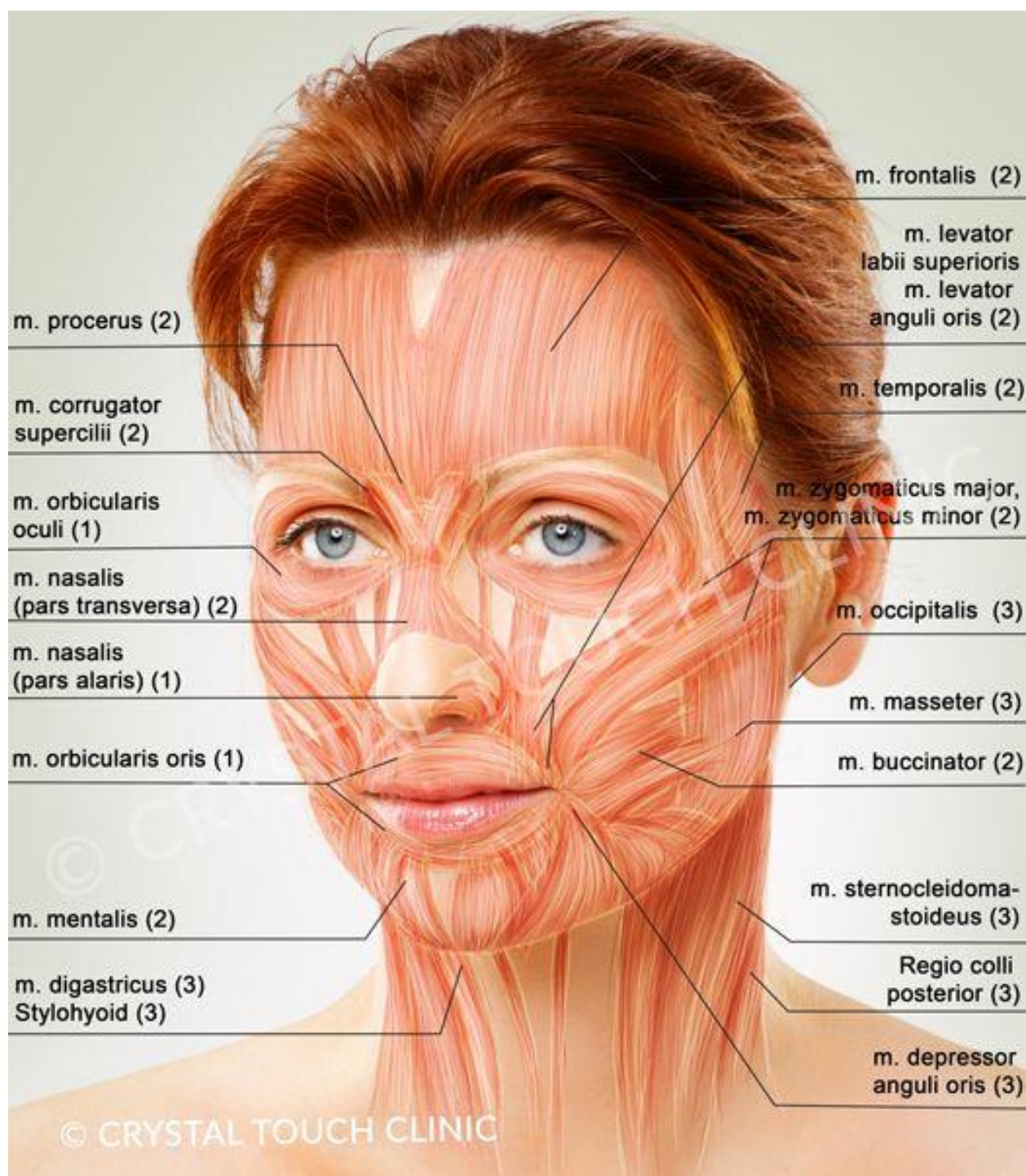


Figure 2.2, Muscle Anatomy of the Head and Neck (Crystal-Touch NI, 2019)



The most common of HNC is squamous cell carcinoma. It is believed that the majority of these cases are due to exposure to and consumption of the toxins and carcinogens found in alcohol and tobacco (Adrien, et al., 2013; Argiris, et al., 2008; Forastiere, et al., 2001; Howard, et al., 2011; Stransksy, et al., 2011). This does not mean that non-smokers/drinkers are not likely to be diagnosed with HNC, it just means that they are less likely. With regard to nonsmokers, Forastiere, et al, (2001) identified, “Nonsmokers are more likely to present with head and neck squamous cell carcinoma at a relatively young or relatively old age as compared with their smoking counterparts” (p. 1891).

More recently, there has been an increase in diagnosed cases of HNC. This increase stems from the human papilloma virus (HPV), which has been added to the small list of leading factors (Verdonck-de Leeuw, Eerenstein, Van der Linden, Kuik, de Bree, & Leemans, 2007; Argiris, et al., 2008; Stransksy, et al., 2011; Howard, et al., 2012; Wittekindt, et al., 2012; Adrien, et al., 2014). While research has shown a shift of decreases in documented cases of typical HNSCC, they have also shown a significant increase of documented cases associated with HPV, which includes squamous cell cancer of the oropharynx. According to Wittekindt et al., (2012) when it comes to the association of HPV with HNC, “[it]can be assumed that oral HPV infections are acquired by sexual contacts (p. 4).

### **Patient**

Receiving a diagnosis of cancer, regardless of its location, can take a toll on both the patient and the provider. Unfortunately, in the realm of healthcare this happens regularly. According to Tobin and Begley (2008), “Breaking bad news to patients or

being present when bad news is given is part of the daily activity of many healthcare professionals, particularly in relation to the giving of a diagnosis of cancer” (p. 30). Great strides have been made through medical research to improve the diagnostic process when it comes to screening for and detecting cancer/pre-cancer cells sooner than later.

However, it does not make the act of giving or receiving such a diagnosis any easier.

It is important to keep in mind that both parties involved are human beings, no two are alike, and each will likely process this news differently than the patient before. Healthcare professionals must be vigilant about providing the patient with the best course of treatment and prevention while attending to the patient’s emotional needs. Ninvier (2009) stated, “By delivering this news adeptly, and by being sensitive to the patients’ response, we can set the tone for their successful journey back to stability and good health” (p. 1).

### **The Role of Internet**

This section is included in order to identify and point out the role of the Internet in the context of patients, and the systems connected to them. It does not intend to evaluate or assess the quality or veracity of the information gathered from various websites. There is no denying that the Internet has become the most readily accessed tool for information about everything that people want to understand better. This section will review the influence of the Internet has on the HNC community. After receiving a diagnosis of HNC, searching the Internet on the topic can provide some measure of comfort and control as it helps people put a label on something (Charland, 2005). On the other hand, Charland (2005) identified that “In this mostly ungovernable social universe, the forces of consumer autonomy are running amok” (p336).

In addition to the fact that the Internet includes a vast amount of information, it also provides platforms for social constructs. With easy access to multiple layers of social media, un-privatized blogs, and never-ending supply of do it yourself (DIY) videos, one can easily become caught in a whirlwind of solid, factual information as well as completely unfounded and unscientific theories without being able to distinguish between the two.

The inclination to research a recently received diagnosis or to identify optimal treatment outcomes has been on a steady rise. The Internet has grown in popularity over the years to the point of inserting itself into the doctor patient relationship. Self-identified researchers allow themselves to draw conclusions that may or may not be based on original credentialed authors' intentions (Hardey, 1999; Pentoney, Harwell, & Leroy, 2014; Park, Kim, & Steinhoff, 2016; Sassenberg & Greving, 2016; Song, Omori, Kim et al., 2016).

The internet has become an integral part in the lives of the patient, caregiver, and or family member by allowing them to connect with others who have had similar experiences and who share such experiences online. The Internet is also a resource to connect them directly to medical professionals (Longacre, Ridge, Burtness, Galloway, & Fang, 2011; Park, Kim, & Steinhoff, 2016; Sassenberg & Greving, 2016; Song, Omori, Kim et al., 2016). Pentoney, Harwell, and Leroy (2014) found that searching for such medical information was “the third most popular online activity.”

Non-medical caregivers may find themselves researching information about those in their care for multiple reasons. They could be researching to find blogs on coping and self-care, they could be researching information to help prepare them for the patient's

next doctor visit, and even to identify the best possible care for wounds and other issues (Teschendorf, et al., 2007; Longacre et al., 2011; Pentoney, Harwell, & Leroy 2014;).

### **Risk Factors**

There are multiple risk factors that contribute to receiving a diagnosis of HNC. The most common is related to smoking tobacco, chewing tobacco, chewing on betel nuts, consuming alcoholic beverages, and low socioeconomic status. There is also more evidence of a connection between HNC and the human papillomavirus (HPV). It was not long ago that men were three times more likely to receive a HNC diagnosis, but as research continues, there appears to be a growing number of cases in women (Forastiere, Koch, Trotti, & Sidransky, 2001; Howard, Lu, Chung 2011; Stransky, et al, 2011; Wittekindt, Wagner, Mayer, & Klusmann, 2012; Adrien, Bertolus, Gambotti, Mallet, & Baujat, 2014; Shrestha, Marla, Shrestha, & Agrawal, 2017). In some countries, the chewing of betel nuts makes up for more than 35 percent of the HNC cases (Wittekindt, Wagner, Mayer, & Klusmann, 2012; Shrestha, Marla, Shrestha, & Agrawal, 2017).

This is not to say that nonsmokers are less likely to receive a diagnosis of HNC. Forastiere, Koch, Trotti, and Sidransky (2001) stated, “Nonsmokers are more likely to present with head and neck squamous cell carcinoma at a relatively young or relatively old age as compared to their smoking counterparts” (p. 1891). Lifestyle, genetics, and access to care have an active role in the list of risk factors in receiving such a diagnosis.

### **Social Stigma of Facial Deformity**

If receiving a diagnosis of cancer is not traumatic enough, the location of it can be cause for additional concern. As stated previously, some physical effects of cancers can be camouflaged by clothing and other cancers may affect internal organs that do not have

an external presence. When the location of the cancer is on a person's face, little can be done to hide it, especially if major oral maxillofacial surgery is required. It only takes one trip to the supermarket to discover that society places a huge emphasis on looks and facial appearance. Roughly one in every four magazines at a standard checkout point has a flawlessly presented model on its cover. That factor alone can take a toll on the self-esteem of individuals with facial deformities or anomalies (Versnel, Plomp, Passchier, Duivenvoorden, & Mathijssen, 2011). Versnel, Plomp, Passchier, Duivenvoorden, and Mathijssen (2011), for which another determining factor in such an equation should be the stage of life when the deformity happens. Also, is it congenital or a result of a disease/facial trauma? REsearchers found that while most of research shows that "adults with congenital facial deformities have a higher prevalence of psychological problems," studies exist that show "no significant increase of these psychological problems in this group" (pp. 110-111).

Macgregor (1990) states, "those whose faces do not conform to the norm it is this very process that is a source of unremitting stress, anxiety, and anguish, all of which have negative implications for personality functioning and mental health" (p. 249). Longacre et al. (2011), argue that this same negative implication might impact the caregiver as much as, if not more than, the actual patient, whereby identifying with both subjective and objective phenomena based on the relationship. While caregivers do not experience the full effect of facial deformity, they can experience all of the same "emotional distress, anxious or depressive symptoms, and caregiver perceived burden" (Longacre et al., 2011, p. 22).

## Caregivers

Caregiving is administered on multiple levels from a variety of professional and non-professional systems. Caregivers provide basic assistance with daily life activities such as help with errands, managing finances, and/or transportation to medical appointments. Caregiver also provide more advanced aid, dealing with a patient's medical care, involvement with bathing, monitoring medicine, or even wound care. The Caregivers Association of British Columbia (2015) as quoted by O'Connor, has defined a caregiver as "anyone who provides unpaid care and support to an adult friend or family member who is disabled, chronically ill, frail or elderly" (p. 165). Caregivers are not identified by the number of hours they assist, or the level of assistance they provide "caregivers on the whole are becoming as diverse as the American Population" (PRWeb/NAC, 2017, p. 1).

Teschendorf et al. (2007) asserts that roughly 80% of caregiving is provided by relatives of patients rather than by professional, paid, caregivers. Stepping into a role of caregiving to a patient with a severe illness involves making major changes to the life of the caregiver as well as to the nature of the relationship between the patient and such caregiver. Unlike the relationship between a paid caregiver and a patient, which is less complicated and is governed by contract and by predetermined rules, the "rules of engagement" when the caregiver is a family member are complicated. There are greater emotional and mental stressors at hand for both the patient and the caregivers.

It is that complexity of the relationship between the patient and the family member/caregiver that requires a specialized approach to family therapy when illness and

caregiving are involved. What are the resources and tools that are available for such caregiver's mental, emotional as well as social state of wellbeing?

### **Illness and Caregiving**

Illness, by its very definition, involves people's loss of ability to function at a normal level that is typical to them. The more serious the illness, the more incapacitated a person becomes. When the illness is severe and life threatening, such as late stage cancer, the caregiving that is required is more intensive and more demanding.

When the caregiving is provided by an agency or an organization, the actual caregiver/employee is trained and is subject to well-defined tasks and agreed-upon boundaries. There is a contract specifying the caregiver's duties on a fee-for-service based formula. However, when the care is provided by a volunteer-member of the patient's support system, there are a myriad of issues that are emotionally and physically complex and deeply affecting the life of such caregiver. Moreover, the relationship between the patient and the caregiver changes, sometimes dramatically.

Caregivers have to give up a significant portion of their personal life in order to accommodate the needs of the patient. Such sacrifice - even if done lovingly - over time, produces subtle resentment, which in turn, causes a level of guilt while, simultaneously, maintaining the love and compassion that created the caregiving relationship in the first place. Interestingly, often, such caregivers do not self-identify as caregivers as stated by O'Connor (2007) "family members will often see the work they are doing as simply an extension of their relational role." (p. 165) Caregivers are required to develop a heightened level of sensitivity to the needs of the patient while attaining a resiliency and an increased level of control over their own emotions and emotional needs, otherwise

there is a risk of causing a situation described by O'Connor (2007) "inadvertent discounting and marginalization of the person requiring care." (p. 165)

### **Biopsychosocial**

The term Biopsychosocial refers to a complete assessment of a patient's medical profile. It is the kind of wide lens review that takes into account the biological, psychological and social aspects of a patient's situation. It was not long ago that there was conversation about whether behavioral and psychological issues belong in the Medical Model. On one side of the argument, mental illness or mental struggles should be considered separately and not be intermingled with the physiological considerations of a patient. Engle (1977) stated, "The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes" (p.196). On the other side of that argument, it was thought that leaving out the aspect of a patient's mental condition was not in conflict with the medical model (Engel, 1977). Ludwig, as cited by Engel (1977) suggested "that sufficient deviation from normal represents *disease*, that disease is due to known or unknown natural causes, and that elimination of these causes will result in cure or improvement in individual patients" (p. 8). Introducing the notion that when treating "disease" the inclusion of the biological, psychological, and social aspects of an individual, can greatly improve overall care. Engle (1980) stated "The biopsychosocial model is a scientific model constructed to take into account the missing dimensions of the biomedical model" (p. 535.)



Borrell-Carrió, Suchman, and Epstein (2004) shared that the George Engel's legacy is based on the idea that "to understand and respond adequately to patients' suffering – and to give them a sense of being understood – clinicians must attend simultaneously to the biological, psychological, and social dimensions of illness" (p. 576). This allows for a patients' subjective experience to play an important role in their healthcare. In the medical and mental health fields, this theory is represented by the three qualities that are unique to a biopsychosocial report. For example, when a patient suffers from a headache and schedules an appointment with a medical care provider, the clinician would be remiss if ignoring life stressors as part of the patient's assessment. According to Lakhan (2006) there are two ways that a health care provider could assess such patient. One way to evaluate would be using the biomedical model, in which the doctor would focus solely on the physical causes of the headache: pain level, pain history, family history, etc... The other way is to review the case including a biopsychosocial review. In the later approach the doctor combines routine medical tests along with the psychological and sociological stressors for the best health outcome for the patient. Engel (1977) distinguishes that "The boundaries between health and disease, between well and sick, are far from clear and never will be clear, for they are diffused by cultural, social, and psychological considerations" (p. 132).

In the case of HNC, the biological aspect would include the physical challenges and ramification of the surgical procedure the patient has experienced. Vickery et. Al (2003) states, "Cancers of the head and neck have a unique presentation of difficulties because of the centrality of this area to various aspects of life" (p. 289). From a biological perspective, HNC patients are greatly impacted physically as the disease not only impacts

their ability for social interaction, it has the potential of interfering with the patient's ability to taste, swallow, speak, chew, and verbally communicate to name a few (Vickery et al., 2003). The psychological aspect is pointed out by Vickery et al., (2003) stated that, "The head and face have a specific role within social and emotional expression and communication, and changes within the anatomy or functioning can have devastating consequences" (p. 290). Katz, Irish, Devins, Rodin and Gullane (2002) believe that "Facial disfigurement has long been viewed as one of the most potentially distressing aspects of head and neck cancer because of the vital importance of the facial region to self-concept, interpersonal relationships, and communication" (p. 104). There is a further physical and psychological strain on the patient and the caretakers as described by Katz et al., (2002) "the life-threatening nature of the illness, the morbidity associated with illness and treatment-induced facial disfigurement and dysfunction, potential changes in role functioning" (p. 103). In addition to the above, there are clear social implications for the HNC patient and caretakers. Waldron, Janke, Bechtel, Ramirez, and Cohen (2013) introduced the idea that "Cancer diagnosis affect not only the patient but also family members and caregivers" (p. 200).

### **Medical Family Therapy**

For many years, the traditional approach to patients who suffered from a physiological condition consisted of a purely medical treatment for the illness and separately, if indicated, some therapy for mental and emotional issues. In the course of the medical treatment, often there was "support and passion," but not necessarily "comprehensive therapy" (Hodgson, Lamson, Mendenhall, & Crane, 2014; Linville, Hertlein, & Lyness, 2007; McDaniel, Hepworth, & Doherty, 1992). Prior

to the introduction of medical family therapy, individuals were treated through “acute-care interventions,” without consideration of cultural context or family circumstance. According to Shapiro (2002), “In addition to their physical impact, most chronic illnesses are accompanied by a mental health burden of anxiety and depression for individuals and their families, economic burdens” (p. 1376).

It was through the George Engel’s design of the biopsychosocial approach that Medical Family Therapy (MedFT) was born. Through dedicated diligence therapists collaborated with medical doctors and other health care professionals to understand what McDaniel, Hepworth, and Doherty (1992) meant when they stated:

“human life is a seamless cloth spun from biological, psychological, social, and cultural threads; that patients and families come with bodies as well as minds, feelings, interaction patterns, and belief systems; that there are no biological problems without psychosocial implications, and no psychosocial problems without biological implications (pp. 1-2).

Historically, MedFT is connected to marriage and family therapy (MFT), Linville, Hertlein, and Lyness (2007) stated that, “The field of medical family therapy (MedFT) bridges psychosocial and physical health, examining the correlations between family, context, and an individual’s physical functioning, offering family therapy interventions for medical illness” (p. 85). This connection has been evolving over the past few decades, however, Hodgson, Lamson, Mendenhall, and Crane (2014) mentions, “MedFT was introduced in the early 1900s, and the field has grown conceptually, particularly with regard to its application and sensitivity to culturally diverse groups of people” (p. 213). This approach, primarily taught in the United States,

has been used successfully throughout the world. Doherty, McDaniel, and Hepworth (2014) have been successful in their endeavor to express that MedFT is a transformational theoretical lens when it comes to medical management including familial and other relational systems in the process of patient care.

Today, MedFT has didactically and clinically trained therapists, like me, to work within complex medical settings helping patients and their families, analyze, process and work through unexpected illness and injuries. Boyd and Watters (2012) emphasized, "... a medical family therapist is envisioned in the context of such interdisciplinary collaboration, working alongside and in collaboration with medical professionals, clinical strategies reflect the medical context of medical family therapy practice" (p. 245). Mental health care providers have become an integral part of the family team as well as part of the collaborative medical team.

In my own experience as a trained MFT, together with colleagues, we have been educated to become familiar with many theories and models to assist families, healthcare providers, and medical specialists. For the purpose of this work I attempt to examine the ideas and concepts of BFST and how these theoretical ideas can be helpful in the approach to Medical Family Therapy, specifically as it pertains to HNC patients and the systems within which they function. Murray Bowen (1975) believed "Emotions are rarely contained within the individual. Rather, they flow endlessly from person to person within the family. Sometimes they spill outside the family to other individuals, family, units, or even societal agencies" (p. 26). It is therefore that Bowen's philosophy is especially applicable when considering a model that is effective when dealing with HNC patients.

## **Bowen Family Systems Theory**

Bowen *Family Systems Theory* is based on Natural Systems Theory. This theory postulates that there are two basic systems that govern human behavior: an emotional system and a thinking system. The human emotional system is similar in many ways to that of other species and is based on a commitment to biology and related sciences. This commitment “led Bowen to develop a theory grounded in system’s thinking as it relates to the natural world” (Burnett, p. 103). The thinking system is unique to humans and ultimately is responsible for controlling behavior and responses to life’s events. In this work, I will refer to BFST in the context and relevance to HNC patients and their family/caretaker system as well as to the professionals interacting with these systems.

Bowen’s *Family Systems Theory* has been an original way of understanding human behavior. In the context of grappling with a severe diagnosis that involves either a chronic condition or death, the approach by Bowen’s theory is markedly different from other models of therapy. It is actually more of a philosophical revolution than a model of therapy. When a patient receives a diagnosis of HNC and an explanation of the dramatic changes it would have on their life, each member of the patient’s family reacts differently to the information. Each such reaction is not limited to the individual who learns about the diagnosis; instead, it creates an emotional chain reaction that travels within the family system and influences all the members, creating a high level of anxiety. This level of anxiety is managed better or worse, depending on the level of differentiation that exists within the family. Reaction to severe illness is always emotional but how such emotions are manifested and how they affect the behavior of the patient and the family system depends on how fused or how differentiated members are. Gilbert (1992) stated, “When

family members were less anxious, they were often able to think through their problems, finding resolution without outside help” (p.8).

Bowen and Kerr (1988) suggest that “thinking of the body as an emotional system may enhance our understanding of a clinical problem such as cancer” (p. 29). The anxiety that is connected to the very word Cancer courses through the body and the psyche of a patient and the whole family system.

The mental health care provider who is familiar with BFST is better equipped to examine a patient’s interaction with the family support system and determine where they are on the differentiation scale. Such knowledge can be useful in helping the system manage the emotional anxiety it experiences and provide them with better tools to manage their acute anxiety, described as “the anxiety generated by day-to-day and situational problems that pose an imminent threat to wellbeing” Burnett (p. 108).

### **Summary**

This chapter has provided a background of HNC diagnosis and treatment planning, as well as a discussion of the literature related to how the patient is impacted, the risk factors, and the difficulty when the Internet is factored in. It reviews the challenges with illness and caregiving. Engle’s biopsychosocial model and how it is uniquely intertwined with Medical family therapy along with an overview of the basic premises of BFST. Despite these results, there is little to no existing literature documenting the journey of a novice medical family therapist entering the challenging and unique population of HNC.

Through the perspective of my work with those impacted by HNC during my one-year rotation, and a review of how I managed my anxieties among the many relationships

experienced, others can learn to expand beyond normal limitations of general practitioners and more common specialties. Additionally, it is my hope my work creates new opportunities for medical family therapists and researchers alike to help advance their experiences and bring new hope to such populations in need.

### **Chapter III: METHODOLOGY**

“Never regard your study as a duty, but as the enviable opportunity to learn the liberating beauty of the intellect for your own personal joy and for the profit of the community to which your later work will belong.” - Albert Einstein

The aim of this study examined my one-year clinical rotation with the OMFS residents and the attending faculty from Nova Southeastern University. In this chapter, I present an overview of why I chose qualitative research, and the rationale for my choice of using autoethnography for the purpose of this study. I reviewed and analyzed my experience through the evaluation of my reflexive journal notes and apply them to the BFST. I will also expand on my role as the primary researcher. This study answers the following research questions: (a) what did I learn about my own differentiation of self, navigating through the many triangles, while managing my own anxiety as a novice medical family therapist from my one-year internship with our OMFS faculty and residents? (b) how can MFT's and other practitioners better prepare for entering such a unique and challenging population? The goal of this study is to use the researcher's own personal journey as a mental health professional entering into the population of HNC. The researcher will examine the many relationships involved in the personal care of HNC patients as well as the professional care. The researcher will re-review the interactions and experience within the systems of the patient, the surgeon, and faculty applying BFST. This study is based on my clinical rotation with the OMFS residents of Nova Southeastern University and attending faculty.



## **Qualitative Research**

I chose to conduct this study qualitatively in order to provide the best representation and analysis of my journey as an MFT entering into the role of a MedFT in a unique and challenging population. In this journey, I learned a lot about my own differentiation of self, while navigating through the many triangles presented in the process of managing my own anxiety facing my own life's challenges. Additionally, it is my hope that this will allow me to help create a pathway to assist future MedFTs and other practitioners with a therapeutic approach to working with this unique and challenging population.

Typically, research involving the field of dentistry is presented in the form of quantitative research. However, Stewart, Gill, Chadwich, and Treasure (2008) identified that using a qualitative method in dentistry “can offer a unique insight into people's personal perspectives providing a more comprehensive understanding of their beliefs, knowledge and attitudes as well as offering greater depth and methodological flexibility than quantitative research methods” (p. 235). According to Hays and Singh (2012), qualitative research is “the study of a phenomenon or research topic in context” (p. 4). The nature of qualitative research allows researchers to immerse themselves into the context of the topic being reviewed (Lewis & Staehler, 2010; Hays & Singh, 2012; Seidman, 2013). In addition to allowing the researcher the opportunity to immerse themselves into the context of the topic, qualitative research allows participants the freedom of “telling it how it is” based on his or her experience with the topic and how they see their world. (Denzin & Lincoln, 2000; Holloway & Jefferson, 2013, p. 3). Therefore, through qualitative methods, researchers can explore the meaning of a human

experience, while taking into consideration the larger context of which the experience is rooted.

Finlay (2011) suggests, “Qualitative research illuminates the less tangible meanings and intricacies of our social world...it offers the possibility of hearing the perceptions and experience” (p. 8). The qualitative research used in this study will be enhanced by applying the concepts of BFST to my own journey entering the field of MedFT. Hays and Singh (2012) refer to this as a “thick description” of the experience, “providing a comprehensive and focused picture of a behavior or occurrence that includes relevant psychosocial, affective, and cultural undertones” (p. 8). Stewart et al. (2008) noted that “an observation of a busy surgery waiting room would arguably attract less attention than an observation in a dental consultation, where there are fewer people and each has a defined, interacting role” (p. 236). Through qualitative research, I was able to explore and formulate a contextual understanding of how BFST allowed me to manage my own anxiety in this particular medical context with surgeons versus general practitioners.

### **Phenomenology**

As related to this study, the researcher conducted a phenomenological exploration of the relationships between HNC patients, caregivers, family, and medical providers applying the BFST. Finlay (2011) claims, “The aim of phenomenology is to describe the lived world of everyday experience” (p. 10). By exploring my own experience through a Bowen lens, I can better understand my own anxieties, thoughts, feelings, and emotions. I am able to then understand how these relationships are impacted in this specialized environment. According to Käufer and Chemero (2015) phenomenology “can have a profound positive impact on our understanding of a host of issues relating to perception,

cognition, and the general meaningfulness of human lives” (p. 4). They further identify that “phenomenology is an ontology of human existence” (p. 4). Almost as if a person is painting a visual picture for the researcher. The objective of the in-depth description is to understand the phenomenon through the viewpoint of the researcher. Finlay (2011) further suggests that phenomenology “offers individuals the opportunity to be *witnessed* in their experience and allows them to ‘give voice’ to what they are going through. It also opens new possibilities for both researcher and researched to *make sense* of the experience in focus” (p. 10). Finley (2011) “Phenomenologists seek to capture lived experience – to connect directly and immediately with the world as we experience it. The focus is on our personal or shared meanings, as distinct from the objective physical world explored by science” (p. 15). Through the application of BFST, I gained an even deeper understanding of the emotions, anxieties, triangles, within the human relationships of the HNC community.

### **Autoethnography**

Autoethnography, according to Adams et al., “offers nuanced, complex, and specific knowledge about particular lives, experiences, and relationships rather than general information about large groups of people. Qualitative research focuses on human intentions, motivations, emotions, and actions” (p. 21). There is limited research investigating the experiences of a certified medical family therapist immersed in an academic setting. It was important to select a methodology that allowed me the opportunity to explore patient relationships on a deeper level. By witnessing relationships with OMFS residents, attending faculty, HNC patients, their caregivers, and families, and applying an autoethnographic component, I was able to provide additional insight into

this specialized population. Jones, Adams, and Ellis (2013) suggest that autoethnographers “choose to explore a particular aspect of themselves or their experiences” (p. 24). Furthermore, Anderson and Glass-Coffin (2013) when comparing autoethnography to ethnography, shared that “in contrast to more traditional ethnographic forms, autoethnographic writing is based upon and emerges from relationship and context” (p. 57). Thus, allowing me the opportunity to use my experience in the context of a MedFT professional entering the world of OMFS within the population of HNC patients, their caregivers and or families. Adams, Holman, James, and Ellis (2014) offer that “With autoethnography we use our experience to engage ourselves, others, culture(s), politics, and social research” (p. 1). As an MFT, it is important for me to select a methodology which provides me the opportunity for a deeper relational exploration with HNC patients and their relationships with the residents in the OMFS program at Nova Southeastern University.

Selecting autoethnography allowed me, as a MedFT professional, to use my education in MFT and MedFT to pursue my interests with the system of patients, their families, and the multiple medical providers they interact with. As the observer of these various relationship systems I was able to witness the interactions within the context of the HNC community. By using myself as the research subject, I was able to explore my own emotions and anxiety while working with such a unique and challenging system. Jones et al., (2013) recognized that what makes autoethnography, a method, requires the inclusion of five objectives for such studies:

“(1) disrupting norms of research practice and representation; (2) working from insider knowledge; (3) maneuvering through pain, confusion, anger, and

uncertainty and making life better; (4) breaking silence/(re)claiming voice and “writing to right” (Bolen, 2012); and (5) making work accessible” (p. 32).

Autoethnography is not void of challenges, it allows the researcher to articulate their findings in unique ways such as dance, poetry, or song writing (Chang, 2016; Jones et. al, 2013).

To accomplish this, I used personal memory data writing exercises as identified by Chang (2016) exploring my journey as the primary researcher encountering a very difficult medical environment. Using the systemic teachings as an MFT and earning a certification in medical family therapy played a major role in this particular medical context with surgeons versus general practitioners. Many have said that this population is not for the faint of heart, however, this study helps to break through that boundary by offering a therapeutic underpinning through the application of BFST.

This approach has been critiqued by other scientifically oriented researchers as unconventional based on the idea that the researcher’s participation is intentionally inclusive and has the potential to influence the data (Ellis, 2004; Ellis, 2007; Ellis, Adams & Bochner, 2011; Chang, 2016). Regardless of the controversy within the scientific/research community, the eccentric variations in writing autoethnographies allow for inclusion of the evocative, interpretive, performance-based, as well as, analytical (Chang, 2016; Ellis et al., 2016). This methodology allows researchers a chance to explore “subjectivity, emotionality, and the researcher’s influence on the research” (Ellis et al., 2011, p. 274), therefore allowing for a systemic and transparent explanation of the data through BFST as they apply to my own anxieties.

### **Analytical Autoethnography**

I consider myself to be innovative and creative. I know that I perform best with organized structure. With that said, I opted to follow the guidelines as presented in Chang's (2016) *Autoethnography As Method* and will follow her format to influence the necessary organization, structure, and objectivity I need for this study. According to Chang (2016), "In analytical writing, essential features transcending particular details are highlighted and relationships among data fragments are explained" (p. 146). She reminds the researcher that "you still need to look at the case in the broader context and to make sense of the relationship between your case and the context" (p. 146). Chang (2016) further explains that "autoethnographic data analysis and interpretation involve shifting your attention back and forth between self and others, the personal and the social context" (p. 125). Additionally, Chang (2016) believes that when done carefully, autoethnography has the flexibility to be creative in combining different approaches through "skillful interweaving of data collection, analysis, and interpretation" that in turn "will ultimately lead to the production of narratively engaging culturally meaningful autoethnography" (p. 126). This process will allow me to bring greater meaning and context to my work while maintaining my focus so that I do not get lost in the content of my experiences.

### **Sample**

While the "visibility of self" has not always been significant to autoethnographic inquiry, Jones et al., (2013) identifies that the "Key to autoethnographic inquiry today is the visibility of the self in research and in writing" (p. 71). Taking that into consideration, I and my experiences are the subject of this study. Since I positioned

myself as the primary participant of this study, it was necessary for me to mention the multiple relationships that would provide a relational context as it pertained to the analysis of my experience (Chang, 2016). I was blessed to be able to complete my required one-year clinical rotation with the OMFS residents of Nova Southeastern University and attending faculty, to complete my certificate in MedFT.

### **Data Collection**

Data collection commenced upon receiving approval from Nova Southeastern University's Institutional Review Board (IRB). Data was collected using my own personal memory and self-reflection. This data was collected from experiences gained from my one-year clinical rotation (January 2015 - December 2015).

### **Chronicling the Past**

Chronicling the past sounds like a daunting and overwhelming task in and of itself. However, it allowed me to return to my journey and explore my own differentiation of self, emotions, and anxieties experienced in such an environment. Chang (2016) suggests that “you break it down to manageable steps” (p. 72). Due to the amount of time that has lapsed between my experience and now, I utilized personal memory exercises (autobiographical timeline, proverbs, and visualizing self) suggested by Chang (2016) to create more vivid memories and allow for a more thorough examination of my data. As a precautionary measure, I referred to each of the patients, caregivers, residents, staff, and faculty using generic terms and pseudonyms.

### **Personal Memory Data**

Chang (2016) identifies “personal memory” as the “building blocks” of autoethnography, while cautioning that a person's memory can be nebulous, leading to

gaps in memory or intermingled remembrances. According to Chang (2016), it is important for me, as the researcher, to openly acknowledge my personal memory as “a primary source of information in your [my] research” (p. 71). Chang (2016) further suggests that another way to invoke personal memories is the use of writing exercises that will allow memories to become more vivid. “Through writing exercises of chronicling, inventorying, and visualizing self, you are encouraged to unravel your memory, write down fragments of your past, and build the database for your cultural analysis and interpretation” (p. 72).

One of the methods I used to recollect my personal memory data according Chang (2016) is to create an autobiographical timeline allowed me to recollect a more vivid recollection of my memory.

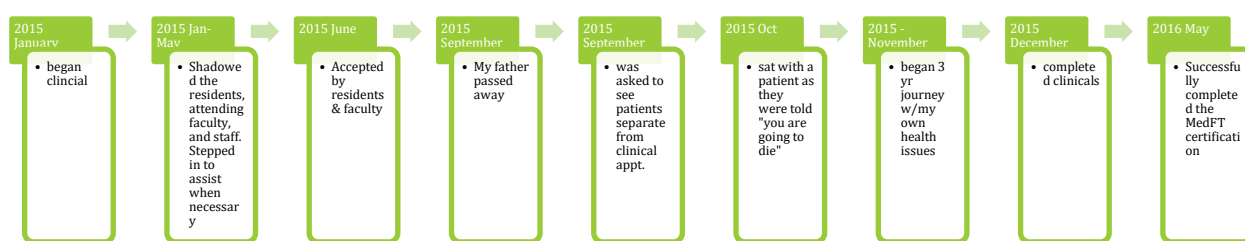


Figure 3. Autobiographical Timeline

Use of the autobiographical timeline in conjunction with the written journals of my clinical experience allowed me to visualize in my mind seeing the events that occurred during my time with the OMFS residents. Chang (2016) identifies that the “autobiographical timeline lists events or experiences from your life in chronological order. It can cover the whole span of life or a limited time period or stage of life” (p. 72). For the purpose of this exercise, I chose the latter and identified some of the major events that took place during my time with the OMFS residents, attending faculty, and staff. As



part of the writing exercise, Chang (2016) suggests that you “select one event/experience from your timeline that led to significant cultural self-discovery.

### **Proverbs**

My understanding of a proverbial themed inventory are brief statements that represent “significant meanings,” “beliefs,” and/or precautionary guidance that have influenced me in my work as an MFT. Chang (2016) recommends listing proverbs “in order of importance that you have heard... describe the context in which each of them was used. Select the one most important to you and explain how it influenced your thought, belief, and behavior” (p. 77). I chose five proverbs that have influenced my work as a therapist, that I found helpful in my journey entering MedFT in such a unique environment: Ride the bus. Don’t drive the bus, don’t push the bus, don’t take the bus hostage. All behavior makes sense in context. The easiest person to change in the room is the therapist. What did the client hire you for? When in doubt summarize.

### **Visualizing Self**

I found the proverb “A picture is worth a thousand words” to be most fitting as it allowed me the best opportunity to convey my journey in the most powerful and efficient way. This proverb allowed me to portray myself as a vulnerable family therapist and novice medical family therapist entering the HNC community through the lens of BFST. According to Chang (2016) “visualization activities mix the collection of your personal memory data through self-reflection and self-introspection with cultural analysis and interpretation through organization and explanation” (p. 80). Through this exercise, I was able to better identify themes that are congruent with BFST, such as times I felt more or less differentiated, when triangles were present, and how I managed through them.

Utilizing this, I was able to identify and understand my own anxiety and navigate through the many triangles presented.

I conducted these writing exercises to evoke the core aspects of my personal and professional beliefs and expectations as a therapist. In order to identify such beliefs and expectations, I identified values of importance to me personally as a therapist and described what that importance meant to me. Through self-reflection, I interpreted the influence such ideations had, if at all, on my overall perceptions at the time, as well, in retrospect.

### **Data Analysis**

Data analysis can be thought of as a balancing act (Chang, 2016). Metaphorically speaking, it can be compared to that of walking a tightrope. From a novice to even the most skilled performer, each has to consider the many variables that allow them to safely get from one platform to another. Chang (2016) stated that, “analysis and interpretation should be seen not in conflict with each other, but as a balancing act between fracturing and connecting, between zooming in and zooming out, between science and art” (p. 127). As an observer, we watch the performer carefully step forward several steps (zooming in), often taking a few steps back (zooming out) to balance themselves as they move towards the intended platform, or as I would like to consider the “end goal.” In relation to an autoethnographic study, I must carefully evaluate each step, often re-evaluating it in order to make the necessary connections and associations to be able to position themselves to reach the next platform.

In order for the researcher to “reach the next platform” each step of my journey was applied to Bowen’s concepts. To do this, I used Titelman and Reed’s (2019) BFST

*Variation of Differentiation and Family Reaction to Death* Chart (p. 31). Table 1 below identifies the eight concepts of Bowen as they closely relate to MedFt. This allowed me to assess the overall system as an outsider from multiple perspectives and review it retrospectively: prior to entering this clinical environment, during my clinical rotation, and now looking back at it. This table explains each of the eight concepts and what low and high differentiation looks like within Bowen's concepts. Thus, making it easier for me to paint a more vivid picture by assessing my own differentiation, emotions, triangles within the different instances I found myself in with regard to the many variables: patients, caregivers, residents, staff, and faculty.

|   |  |
|---|--|
| <b>Low Differentiation in the Family</b><br>Closed communication in the family  | <b>High Differentiation in the Family</b><br>Open communication in the family  |
| <b>Triangles</b><br>Triangles increase with chronic illness and death in the family; more blaming   | <b>Triangles</b><br>Less triangling; dealing one-to-one with members in the family   |
| <b>Nuclear Family</b> <ul style="list-style-type: none"> <li>• Less Stable</li> <li>• More emotional fusion</li> <li>• More unresolved attachment</li> <li>• More grieving</li> </ul>   | <b>Nuclear Family</b> <ul style="list-style-type: none"> <li>• More stable</li> <li>• Less emotional fusion</li> <li>• Less unresolved attachment</li> <li>• Less grieving and more resilience</li> </ul>  |
| <b>The Family Projection Process</b><br>More blame and scapegoating   | <b>The Family Projection Process</b><br>More responsible for self  |
| <b>Emotional Cutoff</b><br>More distancing, tearing away  | <b>Emotional Cutoff</b><br>Autonomous connection   |
| <b>Multigenerational Emotional Process</b><br>More intensity, chronic anxiety, and more family member experience greater impact from shock waves  | <b>Multigenerational Emotional Process</b><br>Less intensity, chronic anxiety, and family members are less impacted by emotional shock waves   |
| <b>Societal Process</b><br>Less involvement with extended family, friends, and community when dealing with chronic illness and death.   | <b>Societal Process</b><br>Dealing directly with death with family, friends, and community   |
| <b>Emotional Shock Waves</b> <ul style="list-style-type: none"> <li>• More emotionally significant shock waves</li> <li>• More instability between couples and between couples and families</li> <li>• More likely to lead to health, work, and education problems, and issues in couples or larger families</li> </ul> | <b>Emotional Shock Waves</b> <ul style="list-style-type: none"> <li>• Fewer emotional shock waves</li> <li>• Will tend to have more stability couples and families</li> <li>• More likely to not have health, work, and education problems and issues in couples or larger families</li> </ul> |

Table 1. Variation in Differentiation and Family Reaction to Death (Titelman & Reed, 2019, p.31)

Table 1 identifies its association with variation of differentiation of self and family reaction to death. These concepts and their identifiers are always present, even when the patients' medical outcome is yet to be determined. It was used as a scale to represent the eight characteristics of Bowen family systems theory identifying the

varying levels of differentiation of self along with being able to identify exception occurrences within these areas.

### **Identifying Exceptional Occurrences**

Working in such a medical context was filled with exceptional occurrences, many of which left me questioning myself, as well as my clinical abilities. It would be an understatement for me to say that “cross cultural experiences opened my eyes to new perspectives, cultural standards, people, and environment” (Chang, 2016, p. 133). With that in mind, I described the content of each exceptional occurrence as it related to similarities and differences while evaluating my own differentiation of self, emotions, triangles, and anxieties that appeared before. Figure 4 below shows the process of both coding and identifying exceptional occurrences that I used in my data analysis process.

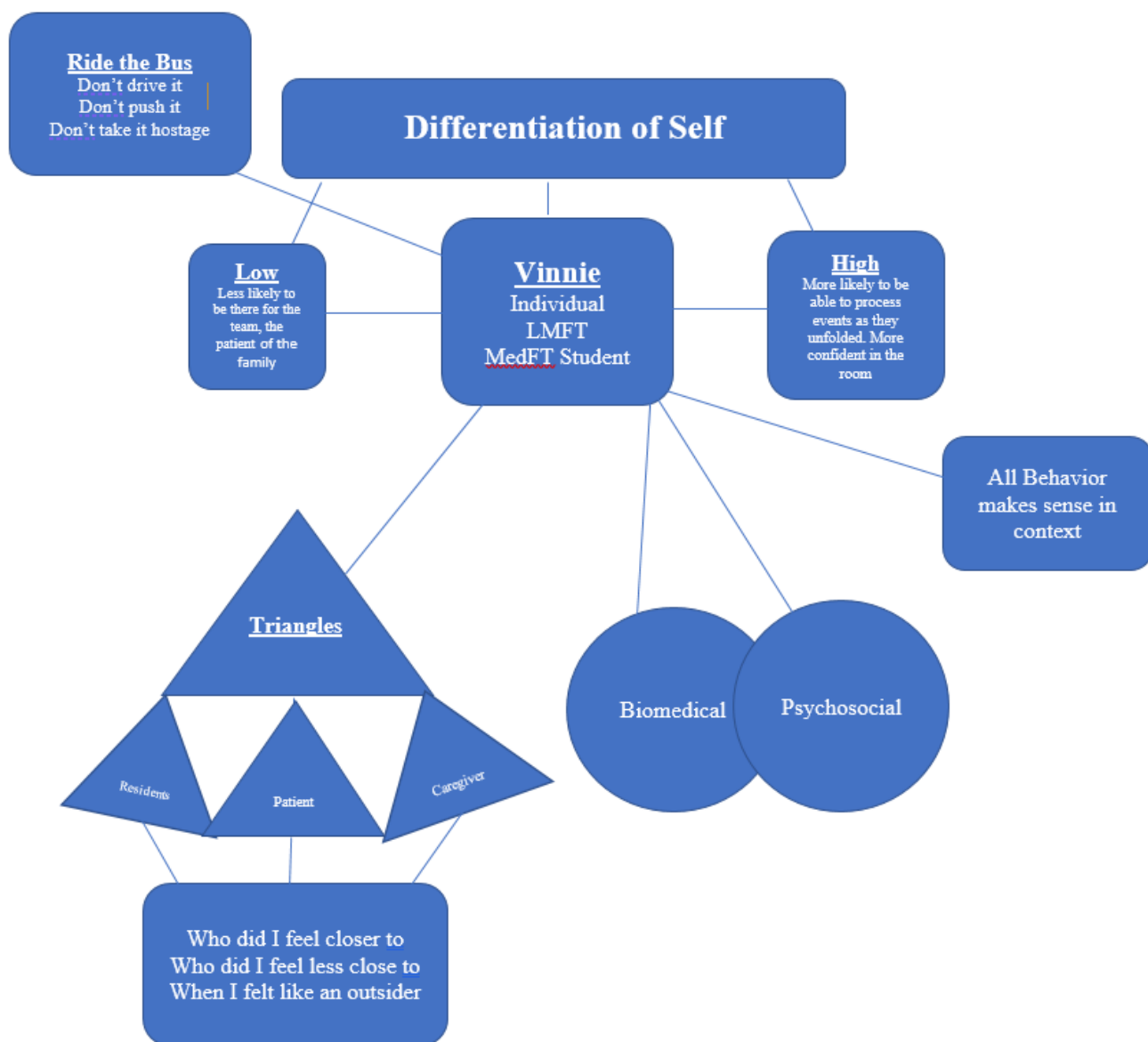


Figure 4.

I believe that many of the challenges faced entering this clinical environment was that it is the first of its kind. As there was no literature to guide me, metaphorically speaking, I needed to “Ride the Bus.” It was important for me to find a way to break through the norms of MedFT to provide a way for future clinicians, like myself, to be able to expand their comfortability beyond the offices of general practitioners and basic

specialists. I hoped that by exploring my own emotions managing through the process, I could also help others that wish to explore more challenging aspects in a given field when they are uncertain if they are “cut out for it.”

After the data refinement process concluded, I then analyzed data through identification of exceptional occurrences (identified in the text portion of Figure 5), analysis of relationships between myself and others (others of similarity, difference, or opposition) and through the comparison of social science constructs found in existing literature, AAMFT ethical/professional standards, and modernist/postmodernist views (Chang, 2016).

### **Autoethnographic Writing**

Once the data was interpreted and analyzed, I translated my findings into a form of readable/interpretable information, in order to successfully communicate the key components identified in this study. A narrative explanation of findings was developed utilizing “constructive interpretation” and “analytical-interpretive writing” (Chang, 2016, pp 14-146), in order to best convey my results.

By incorporating BFST in my study, epiphanies organically occurred during the analysis phase. The process ensured that I maintained the authenticity to autoethnography allowing autoethnographers to “...retrospectively and selectively write about epiphanies that stem from, or are made possible by, being part of a culture and/or processing a particular cultural identity” (Ellis, Adams, & Bochner, 2011, p. 8). These newly discovered epiphanies between the lack in literature and my experiences has evoked a new level of curiosity and implications for future research which will be discussed in chapter 4.

### **Constructive Interpretation**

When conducting an autoethnography, there is a component of personal development, whereby Chang (2016) stated, “comes through arduous self-examination” (p. 141). Incorporating BFST allowed me to do a thorough “self-examination” through my own stories of this experience. Stories of my experience while applying BFST allowed me to interpret my own emotions in the process of navigating such a unique and challenging community.

### **Analytical-Interpretive Writing**

It was through the autoethnographic writing processes that I was able to gain a richer experience through the realization/identification of unknown epiphanies, emotions, and processes which was necessary to my experience and required for the authenticity of this study. Chang (2016) recommends, “keeping a balance among description, analysis, and interpretation in qualitative research and writing is applicable to autoethnographic writing” (p. 146). I maintained this balance through the opportunity it provided me to clearly differentiate between the connections and separations within the context of this unique environment and my differing relationships with the residents, office/clinical staff, and attending faculty given my interconnectedness.

### **Quality Control**

Traditionally, research methodologies require the researcher to be as removed from the data and unbiased as possible. In contrast, the autobiographical/self-narrative component of autoethnographic research allows the researcher to be an active component.



In an effort to avoid the “pitfalls” in doing autoethnography, I chose to follow Chang’s (2016) cautionary advice of five pitfalls to avoid when using autoethnography:

(1) excessive focus on self in isolation from others; (2) overemphasis on narration rather than analysis and cultural interpretation; (3) exclusive reliance on personal memory and recalling as a data source; (4) negligence of ethical standards regarding others in self-narratives; and (5) inappropriate application of the label ‘autoethnography.’ (p. 54)

## **Chapter IV: RESULTS**

“Bowen’s theory pursues an ever-broadening scope that incorporates an entire relationship system. Understanding the system and working for personal change within it produces a powerful effect, not only upon the individual but on the entire system.” (Gilbert, 2004, p. 11)

The purpose of this qualitative study was to paint a portrait of my journey as a novice MedFT working in a medical setting with HNC patients as observed through a BFST lens. Data was collected utilizing Chang’s (2016) personal memory data collection writing exercises. To organize the collected data, each of the writing exercises was separated into themes based on the eight concepts of BFST. This allowed me to fully explore the many experiences of my own differentiation of self in multiple contexts. Each experience was investigated to give meaning in relation to my research questions:

- (1) What did I learn about my own differentiation of self, navigating through the many triangles, while managing my own anxiety as a novice medical family therapist from my one-year internship with our Oral Maxillofacial faculty and residents?
- (2) How can my experience help future MFT’s and other practitioners to better prepare for entering such a unique and challenging population?

### **About the Artist**

The following sections are narratives painting my journey as a medical family therapist in training working in a medical setting with HNC patients. My journey began long before I even knew I was in one. Instead of committing myself to college right out

of high school, I met someone and chose to marry at a very adult age of 19. It was not until after I divorced 18 years later, that I found my calling and committed to pursuing a college education. I never dreamed I would find myself wanting more after finishing my first degree. What I never expected was how much a homework assignment could have an impact on what was to come.

Returning to school later in life came with many unexpected obstacles. Fortunately, I have always tried to view each obstacle as an opportunity to do something different and being older gave me many different perspectives from life's experiences. For as long as I can remember, I have always believed that when one person in the family gets sick, the entire family gets sick. What I did not realize is that that "belief" was not as black and white as it appeared on the surface. Varying levels of anxiety behind the canvas only gave it that appearance. With time running out to finish my degree program, I was re-introduced to Bowen Family Systems Theory and my color palette took on a whole different meaning.

### **A Blank Canvas**

According to McDaniel, Doherty, and Hepworth (2014), a team oriented health care approach lends itself to collaborative work by utilizing professionals such as medical family therapists who serve to bridge the gap between multiple systems. Traditionally, medical family therapists work within the auspices of general practitioners or basic specialists such as pediatricians, oncologists, and/or obstetricians. Working in the dental community through graduate and post-graduate school, I was exposed to a whole new world with Oral Maxillofacial Surgery. As part of the certification program to become a medical family therapist, I was required to complete a one-year rotation in a medical

environment. As an active doctoral student working on my Ph.D. in MFT, I considered working in a hospital. Cleveland Clinic was in the process of building their own cancer facility that would include an HNC unit, only it would not be ready in time.

Opportunity knocked and I was prepared to go where no one had journeyed before. If they did, they did not document it for academic purposes. With little to no literature to offer guidance, I took the opportunity to break the barrier and enter a community of unknowns for someone of my credentials. After securing the appropriate authorizations, I found myself entering a collaborative relationship with the OMFS team of Nova Southeastern University. Without having any directions where to start, I jumped right in. I shadowed for a while, watching the varying levels of anxiety and triangles unfold before my own eyes.

When people ask me about my dissertation topic and what I hope to get out of it, I excitedly talk about the many patients and caregivers that can benefit from working with a medical family therapist. I am often met with the same expression of “that takes a special kind of person” to work with that population. Is that the case or is it because people might be afraid to face their own emotional self when dealing with someone who’s surgical procedure cannot be easily camouflaged?

### **The Color Palette**

For the purpose of this study, I used data collected through a personal memory data collection process and applied it to my experiences using BFST concepts. I explored my own differentiation of self and instances of triangulation during the process of getting my feet wet as a medical family therapist in the unique and challenging discipline of the dental community. Additionally, I explored various aspects of this journey through my

own feelings and emotions in an effort to help others connect with themselves and be able to use their skills to work in such environments.

One important component of the process I “painted” here, is the set of key concepts of BFST. In order to truly understand my journey through the Bowen lens, I feel it best to give a more “colorful” meaning to the concepts involved:

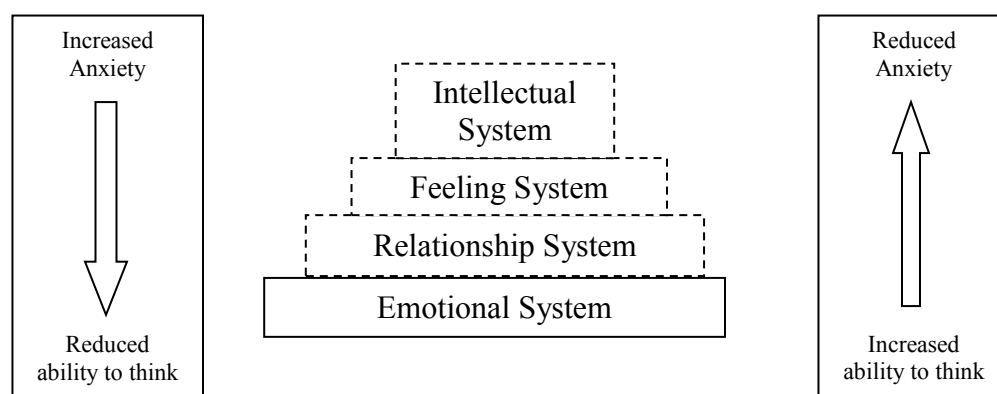
1. The Emotional System – is a multigenerational concept that operates as a whole in which each member affects all of the other members.
2. Individuality & Togetherness – whether we recognize it or not, the family influences how we react/respond in different situations. Both the positive and the negative elements we like or dislike about ourselves, all have come from our experience with our nuclear family.
3. Differentiation of Self – is not limited to the individual. This is how one distinguishes how they think (intellectually) and/or feel (emotionally), alone or as a collective group, and provides an explanation of behaviors in different situations.
4. Chronic Anxiety – is not triggered by any one event, it is rather influenced by many factors and does not have a particular timeframe associated with it. This concept is not the same as acute anxiety, which is triggered by fear and typically associated with an immediate crisis.
5. Emotional Triangles – the strongest part of a triangle is the base, made up of a two-person system that works smoothly when nothing goes awry. However, when anxiety increases, a third person is always triangulated into the system in an effort to reduce or distract from the anxiety.

6. Nuclear Family Emotional Process – the family is considered an emotional unit (pointing back to the idea that when one family member gets sick, the whole family gets sick). Whatever affects one component in the unit, affects the whole unit.
7. Multigenerational Emotional Process – This is the way matters are handled or perceived over generations, with factors including but not limited to: marriage/divorce, religion, money, survival, sickness, or death.
8. Symptom Development – A disruption in the system. Based on how differentiated one is or is not is a determinant of how long the symptoms, driven by anxiety, last or how severe they are.

(Bowen & Kerr, 1988; Gilbert, 1992; Gilbert, 2004; Burnett, 2019).

As students, we learn about these eight concepts of BFST in the context of the nuclear family. In the master's program we very briefly explored BFST. However, in the doctoral program, not only is there a whole semester dedicated to getting to know the theory, there is an additional semester to explore the theory on a much more personal level, if one so desired. As I performed the writing exercises of the personal memory data collection, I was quickly seeing the patterns of anxiety and its ability to move from family member to family member, only it did not stop there. Times were experienced where this same anxiety travelled through a room of professionals. According to Gilbert (2004), "Whatever affects one affects each one in the system. This is, anxiety moves easily from person to person in the group" (p. 6). It is how one responds that determines their level of response, or level of differentiation.

The emotional system generates our fight or flight responses to situations, a way in which one reacts to save oneself. It is a gut level instinct regardless of right or wrong, driven by our most basic instinct to survive. In addition, it is closely connected to the other main systems: relationship, feeling and intellect. When anxiety increases, our ability to think beyond our emotional system is greatly reduced. On the contrary, when anxiety is low, we have the ability to think beyond our emotional system because in those times we are not in a position whereby we feel our survivability is threatened.



On the basic level, BFST postulates that we as humans operate on varying levels of differentiation. The higher the level of ones' differentiation, the more he or she is able to access their "Intellectual System" in times of increased anxiety. When anxieties increase, one who is truly functioning with a higher level of differentiation can think more clearly and does not necessarily act based on his or her emotions. On the other hand, someone who is functioning on a lower level of differentiation tends to act based on his or her emotions as they are not capable of thinking logically when anxiety is on the rise.

Through this study, I will demonstrate that systemically, the anxiety of a family unit is not limited to the family. Sickness in a family brings with it a heightened level of anxiety, but when that sickness is related to cancer, it has the potential to take that anxiety to a whole new level.

### **The First Stroke**

The purpose of this qualitative autoethnographic study was to offer MedFT's and other health professionals with an up close and personal portrait of my journey as a novice MedFT in training, entering into a unique and challenging environment in the dental community. I used the data collected through the personal memory data writing exercises and apply these concepts to my experiences. I also used selected proverbs to aid with the organization and have structured the following narratives using headings that are comprised mainly of proverbs. Each proverb was explored to identify meaning in relation to my research questions:

- (1) What did I learn about my own differentiation of self, navigating through the many triangles, while managing my own anxiety as a novice medical family therapist from my one-year internship with our Oral Maxillofacial faculty and residents?
- (2) How can my experience help future MFT's and other practitioners to better prepare for entering such a unique and challenging population?

The dichotomy of my proverbs writing exercise proved advantageous in my process. According to Gilbert (2004), "systems thinking strives to look at the emotional process going on among people, while never losing sight of the facts of a given situation. Rather than trying for control or blaming the other, one tries to better manage oneself and



one's own contribution to the situation" (p. 2). It was not until I was working through my personal memory data collection process for this chapter that I was able to connect how the proverbs that have influenced my work as a therapist became such an extraordinary addition to my work. I found the flexibility of my proverbs very helpful.

**Ride the bus. Don't drive the bus, don't push the bus, don't take the bus hostage.**

As an outsider looking in, I was unable to be in traditional "therapist" mode. For several months I had to "ride the bus." Originally, not knowing how to fit in, the residents not sure of my place in the system, even I did not know my place in the system. Without being aware of it, I came to realize that I was very cautious in my actions. There was a lot going on with each patient interaction. To a certain extent, I was managing my own level of differentiation. I could not get upset if/when the residents forgot to include me in the patient discussions, or when the team would enter the room. According to Burnett (2019), "the most well recognized of all of Bowen's concepts, differentiation of self is also probably the most complex, multidimensional, and difficult to grasp of the eight" (Burnett, in Reiter, 2019, p. 111) and yet, it is found in every possible interaction. To me, the most intelligent thing to do was learn from the many emotional units that came into play until the time came when the team felt more comfortable with my presence. I would like to think, that in this instance I maintained a higher than average differentiation of self. I needed to learn, I needed to witness, earn my place in the room, and most importantly, I needed to be okay that I was not there for therapy just yet.

As a therapist, it was natural for me to follow this proverb. Also, I feared interrupting their process too soon could give me the appearance of an intruder and possibly make this discipline difficult to incorporate a collaborative healthcare approach

outside of traditional medical teams. They already did not understand what we as professionals bring to the table.

From another angle, I needed to make sure that what was going on in my own life did not follow me into the situations I could find myself in. Having my own health concerns, coupled with multiple family health crises, I needed to be mindful of my own well-being as a participant in the emotional process. After all, I am not the first person to be dealing with aging parents, their declining health, while having a major task at hand. How better to do this than “ride the bus.”

If I am mindful of my differentiation of self in a given instance, the more apt I will be to be able to just “ride the bus.” Remaining focused on being at the higher end of the differentiation scale, if that is even possible, could allow me “the ability to separate thinking from feeling, and choose which will predominate at a given time” (Gilbert, 2004, p. 27).

### **All behavior makes sense in context**

This falls in line with “differentiation of self,” in my original position as a “fly on the wall.” These interactions and related behaviors did make sense in context. They all took place at a local hospital in a medical suite that allowed the location to operate as an advanced level dentist’s office, making the environment even scarier. The rooms were much larger than a standard dental office, allowing for the team of residents, faculty, staff, the patient, and often multiple guests of the patient. If you think about it, “all behavior” does “make sense in context,” possibly even expected behavior based on the emotional unit of the patient’s nuclear family. The patient that does not answer the

questions of the residents because the caregiver in the room has taken the room hostage is an example of this.

From Natural Systems Theory, this would ascribe to multiple concepts within the theory. One example would be the level of differentiation of self of that caregiver could be operating from the “lower end” of the Differentiation of Self Scale. Gilbert, 2004, shared that, “At the lower end of the scale, people are more emotionally fused in their relationships. They also show evidence of another type of fusion between their emotional (automatic) and intellectual functioning. That emotional/intellectual fusion may derive from the relationship fusions one grew up on.” As stated previously, the higher the anxiety, the more likely their emotions are getting in the way of their ability to think clearly. If the family pattern is that the one least ill in the family unit gets to speak on behalf of the patient, they may not even be aware of this underlying emotional process; it is how the family has functioned for generations when illness enters the picture.

This “hostage” situation mentioned above can originate from any angle; the patient, the caregiver, the resident, the attending faculty, and/or the staff. Any one of these listed have the capacity to take the room hostage, creating multiple triangles. Each participant can form a triangle in which each member in the room tries to find that one person who is on board with their narrative creating interlocking triangles. According to Bowen, as quoted by Gilbert (2004), “A two person system may be stable as long as it is calm, but when anxiety increases, it immediately involves the most vulnerable other person to become a triangle. When tension in the triangle is too great for the threesome, it involves others to become a series of interlocking triangles” (p. 41). The thought of cancer has the potential to open the flood gates of anxiety, where the fear of the unknown

can blur the notion of who is for and/or against you. Being able to identify the context of where someone is reacting from can help keep the communication process in the room on a more intellectual level by not falling into the invisible hostage situation.

**The easiest person to change in the therapy room is a therapist**

In any environment, the easiest person to change in the room is always yourself. As much as we would like to change the behavior or reaction of someone else in the room, it is impossible. And if attempted, this can create even more anxiety and chaos in an already unstable system. It is much easier to look at yourself and identify what changes you can make to be different in or to the situation.

As clinicians, it is very easy to get triangulated into the exchanges of the patient and their caregivers, especially since we are in a helping profession and have likely been a family caregiver a time or two. As BFST would have it, once again it depends on the level of differentiation of each person in the room. We can relate with caregivers on a deeper level, making it easy to join with them and empathize with their sacrifices as the similarities take on a more personal level. It is no different when clinicians and practitioners are engaged in his or her own personal struggles. Performing outside basic functioning or beyond can be very challenging, knowing that our own anxieties can blur our ability to access our thinking system. In the end, we are all human beings operating in the same fashion. Our actions might be different, but we all go through the same basic instinct of fight or flight.

Once again, the scale of differentiation of self plays a major role. Like triangles, they are ubiquitous. A person functioning higher on the scale of differentiation could be able to identify his or her role in the anxiety of the room and smoothly shift the triangle.

### **Connecting the Dots**

Throughout this journey, I had the privilege of being exposed to many variables of dots to be connected. Each variable brings his or her own nuclear family into the picture. With the help of BFST I was able to re-experience each of the interactions through a completely different view. Unable to account for the thoughts and emotions of the patients and the doctors, I am able to provide a view of my portrait as a young MedFT encountering a very different medical situation. To do this, I explored my experiences with the different people I was fortunate to interact with, such as: the patients and their caregivers, the residents, the office staff, the clinical staff, and the attending faculty. The dots to be connected were through my explorations using Titelman and Reed's (2019) *Variation in Differentiation and Family Reaction to Death* chart. As much as I would have hoped for more accounts of higher functioning differentiation of self in my journey, I came to understand that just like any other human being, I have moments of where I am not capable of thinking beyond my emotions.

### **Patients and Caregivers**

The patient base consists of any person in need of dental care or follow-up from previous dental care or major surgery. The caregiver is identified as the individual that drove them to the appointment, which in each case was someone involved in the patient's care. For the purpose of this section, I will only connect with HNC patients and their caregivers.

I remember the first patient I met. An elderly gentleman was the first time I saw in person what a worst-case scenario might look like. After his appointment, I learned that 22 years prior, when he received radiation therapy, they radiated the entire area of his

mandible in an effort to combat the negative effects of HNC. He lost his entire mandible and part of his tongue in the process. When I met him, it was right after the holidays (Thanksgiving, Christmas, New Year's). The man had not spoken a word in over 20 years. He used a towel as a bib to wipe the drool that he was not able to swallow like the rest of us. Additionally, he carried with him a medium sized dry erase board and marker to communicate with those around him. To be honest, he did not need to say anything.

Surprisingly, the energy he brought into the room was one of peace. Someone who was so physically facially deformed, his lower lip literally sat outside his larynx. He had not spoken a single word in many years. He was kind and energetic. It was encouraging to witness the interactions between him and the residents while they shared lots of laughter together, filled with good wishes that first visit of the year. My first patient forever made a positive impact on my life. A man who has so much to be angry or sad about, was joyous and full of life. I did not communicate with him this visit, as it was my plan to shadow until the team felt comfortable with my presence. With this particular patient, we worked together later in my time at the hospital, in which I will later expand on.

There was also the businesswoman who treated her cancer like an inconvenience. As a successful business owner, she kept herself very busy. She always wanted her appointments to be short and quick so she could "get back to work." Another patient was a single man who had three cats that he adored. I met him on the day he found out that he needed major surgery that would require a 5 to 7-day hospital stay. He was concerned his job would terminate him because he might have to miss 20-30 days of work. Like most

cases, when these conversations happen, it is often well into the disease when waiting to proceed could be costly, possibly even deadly if left unattended.

In another instance, I was asked to offer therapy to a patient and their daughter. Before agreeing, I cleared it with my clinical rotation supervisor, Dr. Boyd. I will never forget the first time I received a call from the resident to see this patient post major surgery, due to a very aggressive tumor in which she lost a large section of her mandible. There was a lot of anxiety between the daughter, who was the patient's primary caregiver, and anyone that walked into the hospital room. The daughter was very anxious about the care her mother was receiving.

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| <b>Low Differentiation in the Family</b><br>I know that in the beginning I had many insecurities entering this environment.  | <b>High Differentiation in the Family</b><br>I would like to believe that more often than not, I was in control of my emotional thinking. (I was not)   |
| <b>Triangles</b><br>Early on I was easily triangulated with the patient and/or the caregiver.  | <b>Triangles</b><br>It was not until the rotation was almost over that I was better able to manage the triangles I found myself in  |
| <b>Nuclear Family</b> <ul style="list-style-type: none"> <li>When I first was able to work with the patients, I struggled to escape the emotional fusions. This could have been due to my father's illness and being a caregiver most of my life. There were many similarities in our stories without ever having to share mine</li> </ul> | <b>Nuclear Family</b> <ul style="list-style-type: none"> <li>After my father passed, I found a sense of resilience and was able to separate my issues from the environment I was in.</li> <li>I began to see the patients as clients and not co-commiseraters</li> <li>I was able to have productive conversations with the patients and their caregivers.</li> </ul> |
| <b>The Family Projection Process</b><br>I did not recognize this in the data collected   | <b>The Family Projection Process</b><br>I did not recognize this in the data collected  |
| <b>Emotional Cutoff</b><br>I felt safe in this area. It made riding the bus quite easy. Not knowing what to do, distancing myself (not physically) from the emotions in the room and just watching things unfold were a big safe zone for me.  | <b>Emotional Cutoff</b><br>I stopped hiding in the background. I felt less anxious around the team.   |
| <b>Multigenerational Emotional Process</b><br>Like my mother, when anxieties are on the rise, I throw myself into my work.   | <b>Multigenerational Emotional Process</b>  |
| <b>Societal Process</b><br>I wanted to throw in the towel when my father passed away   | <b>Societal Process</b><br>As a creative individual, I found many opportunities to stay busy at the clinic. I assisted with patient care to work more closely with the residents.   |
| <b>Emotional Shock Waves</b> <ul style="list-style-type: none"> <li>My father's passing</li> <li>The start of my own health battles</li> </ul>   | <b>Emotional Shock Waves</b> <ul style="list-style-type: none"> <li>I became a more active participant</li> </ul>   |



When this part of the journey began, I did a lot of “riding the bus.” Early on, the patient and/or the caregiver did not even know I existed. I was just another body with the team, hiding out in the background. It was not until after experiencing a personal loss, that I was able to find the ability to think beyond my emotional system to what I thought was closer to my intellectual system. I discovered through this exercise, that when it came to my interactions with the patients and caregivers, however, I functioned more from a position of lower differentiation of self.

### **Office/Clinical Staff**

Despite the amount of dental traffic that flows in and out of this hospital location, it is held together with a small staff base, one receptionist and two dental assistants, all of whom were university paid staff. In my efforts to fit in, I found myself helping anywhere and everywhere that I could. During times that hospital rounds ran late or there were other gaps in the schedule, I would assist the receptionist with filing, organizing, stapling forms, even taking messages when the phones were busy.

With the dental assistants I was just as involved. In the clinic, I would help with patient care, cleaning the rooms after visits, setting up the rooms for the various procedures, assisted with keeping the shelves organized and stocked, even taking inventory of materials. No job was too small.

In these times, I looked for every possible way to learn as much as I could about this environment. How did the staff make it all look so easy? From an outsider’s view, they gave the appearance of cohesiveness. It was not long before the reality of the situation came to fruition before my eyes. As much as I tried to avoid getting caught up in it all, it was a different kind of learning process for me.

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| <b>Low Differentiation in the Family</b><br>I would like to believe I was a blend of both.   | <b>High Differentiation in the Family</b><br>I would like to believe I was a blend of both.   |
| <b>Triangles</b><br>I did commiserate when triangled in, more about the “work” things. I was the newbie here, they each wanted me to side with them, each vying for my loyalty.                | <b>Triangles</b><br>In time, I was able to avoid being triangled in the office antics.  |
| <b>Nuclear Family</b> <ul style="list-style-type: none"> <li>With the assistants it was like having an older sister and a younger brother, each with its own emotional relationship</li> </ul> | <b>Nuclear Family</b> <ul style="list-style-type: none"> <li>My relationship with the receptionist was the least emotionally fused of the office team.</li> </ul> |
| <b>The Family Projection Process</b><br>I did not recognize this in the data collected.  | <b>The Family Projection Process</b><br>I did not recognize this in the data collected.   |
| <b>Emotional Cutoff</b>  | <b>Emotional Cutoff</b><br>I needed these relationships to earn my place in the system, but they were not my main purpose for being there.                        |
| <b>Multigenerational Emotional Process</b><br>Following in line with how my family dealt with exposure to illness was not an option  | <b>Multigenerational Emotional Process</b><br>I had to be different. While this rotation was for me, it was not about me. This was new territory to explore.      |
| <b>Societal Process</b><br>I struggled with this, especially when my father passed. Hiding under a rock, if possible, would have been sufficient.  | <b>Societal Process</b><br>I learned how to be an active participant in and out of the room   |
| <b>Emotional Shock Waves</b><br>I did not recognize this in the data collected.  | <b>Emotional Shock Waves</b><br>I did not recognize this in the data collected.   |

These relationships, while important to my process, were more like an extended version of my regular job. At the end of the day, we were still co-workers working at a remote location as an extension of the university. It was very important for me to

maintain my position as a MedFT in training. I often had to remind the clinical staff that during these hours, I was not Vinnie Bennett, the dental implant coordinator.

### **Residents**

In the process of preparing for this clinical rotation, I met with some of the residents and faculty before entering the hospital. I wanted to learn as much about this population firsthand as I could. I heard many stories of how the majority of the patients seen were addicts of one kind or another, typically homeless, lower socioeconomic classes, heavy smokers, drinkers, chewers, and often with mental illness. Such patients often had little if any access to healthcare. I tried to educate myself accordingly to be prepared for some of the situations I may be a part of. I would look at countless pictures in books from the library and online. I even read some of the residents' class textbooks to help with the language. It was my hope to look at each patient with compassion and kindness, from a position of not knowing.

When I first began, I shadowed the team for a few months. I wanted to become more comfortable with the lingo as it applied to real life situations and become familiar with the doctor, patient, caregiver interactions. I did not want to interfere with their important visits, so I stood in the background.

For several months, I watched how the residents entered the room. I watched how they performed introductions, often with a quick glance around the room, not always fully introducing everyone in the room. I watched how they positioned themselves in the room. I watched their mannerisms, how they eagerly and tirelessly paid attention to the attending faculty's words and actions. As an outsider, early on, I was nervous entering the room with the team. I did not want to confuse anyone, I wanted to help them

understand and learn about people like me and what a medical family therapist had to offer, to know that as a licensed psychotherapist, I was there to learn about a population that I had only read about in articles and books. For such a “neglected population” I wanted to see how people like me can be helpful and work with practitioners to benefit them.

I was happy to be able to help anywhere I could. Looking back, I believe it helped me become a more interactive participant throughout my experience. I could have sat in the front office or in the break room in between HNC patients. I worked hard to get this location approved, so I needed to immerse myself in the opportunity. I wanted to see how and where people with my credentials could fit in and make a difference. Being a systemic thinker, it only made sense to learn about the entire system, and what better place to start than right in the middle of where it all happens?

I enjoyed watching the residents sharing their knowledge with the patients. They would draw diagrams on the tray papers to provide a better visual for the patient’s understanding. For the most part, the residents I worked with were very kind and gentle, empathetic with the patients. I wish I could say that for all of them.

By mid-June they began to remember to include me in the introductions and they would look for me before assembling and entering the exam rooms. They even began to include me in patient discussions prior to entering the room when they would review radiographic exam results (e.g., CT and PET scans). Not long after they let me enter their circle, they would ask me to go into the room of patients with other facial traumas and not just for HNC patients.

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| <b>Low Differentiation in the Family</b><br>It was my greatest hope to be able to avoid functioning from a position of lower differentiation.  | <b>High Differentiation in the Family</b><br>I needed to be on top of my game.  |
| <b>Triangles</b><br>Originally, I was not as successful as I had hoped at avoiding every emotional triangle.   | <b>Triangles</b><br>In time I was able to create more one-on-one relationships with most of the residents (though not all) .  |
| <b>Nuclear Family</b> <ul style="list-style-type: none"> <li>• Struggled to find my place</li> <li>• I could not be Vinnie – the implant coordinator</li> <li>• More unresolved attachment</li> <li>• More grieving</li> </ul>                 | <b>Nuclear Family</b> <ul style="list-style-type: none"> <li>• In time, I became Vinnie – the MedFT</li> <li>• I was asked to work independently with patients and caregivers</li> <li>• Less unresolved attachment</li> <li>• Less grieving and more resilience</li> </ul> |
| <b>The Family Projection Process</b><br>I was still “riding the bus.”  | <b>The Family Projection Process</b><br>Breaking away from family patterns, I became the change I wanted to see in the room.  |
| <b>Emotional Cutoff</b>  | <b>Emotional Cutoff</b><br>I was becoming Vinnie, the MedFT in training   |
| <b>Multigenerational Emotional Process</b><br>Just like being the youngest in my family I was the newest/youngest member in this new process. I allowed myself to function as the whipping boy by being at the beck and call of the residents. | <b>Multigenerational Emotional Process</b><br>As time went on, I continued to be the change I wanted to see in the process.   |
| <b>Societal Process</b><br>I desperately wanted/needed to fit in.  | <b>Societal Process</b><br>After the loss of my father, I was more able to be a part of the processes presented in my role as a MedFT.  |
| <b>Emotional Shock Waves</b> <ul style="list-style-type: none"> <li>• Desperate to fit in</li> <li>• I made myself available to do tedious tasks</li> <li>• Separating myself from “Vinnie – the implant coordinator”</li> </ul>               | <b>Emotional Shock Waves</b> <ul style="list-style-type: none"> <li>• Through patience and perseverance, I earned my way in the room</li> <li>• I was earning a new level of respects from the residents</li> <li>• I was able to be a part of the team</li> </ul>          |

In hindsight, this exercise allowed me to see that initially my clients were the residents. While they had not hired me to do a job, they needed to know that they could have. I needed to find creative ways to show them that I was capable of being Vinnie – the MedFT. They already knew that I was capable of being Vinnie – the implant coordinator. Fortunately, working with them outside the patient experience gave them an additional level of trust since I was very careful to keep those boundaries clear. They willingly gave me the space I needed to become curious about their understanding of patient relationships.

### **Attending Faculty**

I was fortunate enough to work with two different attending faculty. While they were polar opposites, I feared them both equally. They were not new to the profession and both knew how to do amazing things surgically with HNC patients. They were able to maintain an outsider position; they enter the room as an expert and leave with their expert status intact. It was their job to educate the residents in the ways they should go.

Each resident rotation came with varying levels of experience from first to fourth year residents. For the most part, the fourth-year residents had each worked hard to gain a certain level of respect from the attending faculty. However, there was the occasional second- or third-year resident who proved themselves early on in their educational process.

Even with these relationships, I felt the need to “ride the bus” as often as possible. I do not recall the time or instance of when I began to be included in the conversations outside of the room. I was still just as intimidated. The anxiety of wanting to fit in often interfered with my ability to think beyond my relationship system. Was this because they

knew me as, Vinnie – the dental implant coordinator, and struggled to understand who I was as Vinnie – the MedFT?

| <b>Low Differentiation in the Family</b><br>I struggled to get out of this zone.   | <b>High Differentiation in the Family</b>  |
|--|--|
| <b>Triangles</b><br>I often found myself stuck in interlocking triangles between the patient, the resident, and the clinical staff.  | <b>Triangles</b><br>When the timing was right, I was able to be who they needed me to be.  |
| <b>Nuclear Family</b> <ul style="list-style-type: none"> <li>• I felt like the unstable piece of this puzzle.</li> <li>• My anxiety of wanting to fit in prevented me from “fitting in.”</li> </ul>                              | <b>Nuclear Family</b> <ul style="list-style-type: none"> <li>• Oddly, after the passing of my father, I found a sense of resilience.</li> <li>• The emotional fusion I had with my anxiety released and I was capable of adding to the team in a complimentary way.</li> </ul> |
| <b>The Family Projection Process</b><br>A sense of hierarchy between faculty and student MUST BE respected.  | <b>The Family Projection Process</b>   |
| <b>Emotional Cutoff</b><br>I hid behind my insecurities.<br>I felt that some of the faculty/patient interactions were stoic, I even made excuses for it.   | <b>Emotional Cutoff</b><br>I managed to learn how to face my anxiety with the faculty.   |
| <b>Multigenerational Emotional Process</b><br>In times of high anxiety, I threw myself into my work.   | <b>Multigenerational Emotional Process</b><br>I broke through family barriers. I learned to balance some of my relationships.  |
| <b>Societal Process</b><br>The anxiety of not knowing where I fit in prevented me from fully participating in the HNC patient process  | <b>Societal Process</b><br>My anxiety lessened and I became a more active participant in the process of HNC patient care.  |
| <b>Emotional Shock Waves</b> <ul style="list-style-type: none"> <li>• Desperate to fit in</li> <li>• I made myself available to do tedious tasks</li> <li>• Separating myself from “Vinnie – the implant coordinator”</li> </ul> | <b>Emotional Shock Waves</b> <ul style="list-style-type: none"> <li>• Through patience and perseverance, I earned my way in the room.</li> <li>• I was earning a new level of respects from the residents.</li> <li>• I was able to be a part of the team.</li> </ul>          |

There is a sense of hierarchy when entering such a faculty/student dynamic. When I was growing up, the teacher sat facing one direction in the room while the students were positioned to face back at them. This did not change as I furthered my education. This positioning was familiar to me. The room was always set up in the same fashion. That person, no matter who, was to be respected, which would explain the possibility that it was the walking, speaking, standing side by side as an equal that prevented me from making the connection.

### **Epiphanies as Focal Points**

Every portrait has a focal point. That spot draws your eye to it and creates a focus for the eye and for the concept of the finished product. Metaphorically, it can be seen as the centerpiece of an experience or as the most influential spot in the painting. In other words, every chapter of a journey can be its own canvas and the epiphany experienced is akin to the focal point that determines the structure of the portrait, as well as its narrative. Much like this dissertation, which began with me not knowing how to take the first step to getting to this point, the epiphany of using BFST helped to bring the structure required to breathe life into my story.

It was not until the final process of applying my emotional self to Bowen's concepts, when I was "connecting the dots," that these epiphanies truly took form. Going into this process I knew that I would have to be in the background at first, learning the lay of the land and the clinical practices of the team. Yet it was not until I organized my data for the second or third time that I was able to stop and identify them. In the first steps of filling in the blanks, while creating the "proverbs," one of my first epiphanies, I realized that my roots as an LMFT inform many of the decisions I am faced with personally and



professionally. Dr. Schooley consistently says, “Everyone is a client until proven otherwise,” a concept ringing truly throughout my work. I had to stop, look, and listen to many stories in multiple concepts laid out before me. Riding the bus and making sense of the behaviors that unfolded in front of me allowed me to fully embrace the application of BFST in my work.

Other epiphanies occurred while applying BFST to my experiences. Another epiphany allowed me to create a more “colorful” and creative outcome. These epiphanies allowed me to quickly identify patterns of anxiety that travelled from family member to family member, from clinical staff to the residents and attending faculty. Additionally, during times of reflection, my own anxiety was reduced. The attending ability to think beyond my emotional system allowed the creative nature of my intellectual system to blend in, providing many opportunities to apply BFST as a unique lens with which to view my work. This offered me an exclusive reflection and understanding of how I was able to start to break away from Vinnie, the implant coordinator, and transition into Vinnie the medical family therapist. It was right before my father’s passing that I noticed this transition.

Working with the clinical/office staff, I struggled to find areas where the two Vinnies showed a level of differentiation. The epiphany here was that my relationship as either Vinnie was not comparable because neither of the contextual paths crossed. To them, I was just Vinnie. I had several epiphanies working with the residents, such as the introduction of the two Vinnies, to suggest we all had something in common; we were there to learn. One epiphany came when I saw a shift when the residents began to include me as part of the team. I went from being an informed outsider, ready to be at

anyone's beck and call, to being sought to enter the room with the team. Thinking back to the idea that "everyone is a client until proven otherwise," the epiphany here was that the residents and attending faculty were "clients" and it was my responsibility to show them what I was capable as a MedFT. I needed to keep these relationships separate. Vinnie the implant coordinator was left at the door every time I entered the threshold of the building.

In order for me to be able to consider my internship successful, I had the belief that one of my jobs was to win over the attending faculty. As I mentioned prior, this was an area where fear consumed me for some time. It was an epiphany that helped me understand where this fear stemmed from. Once again, it was the BFST lens that enabled me to understand how beneath it all stood a hierarchy of respect that had been instilled in me since I was a child, not being able to be seen as an educated equal in order to be a complimentary part of the team.

### **A Summary of the Portrait**

The purpose of this study was to create a portrait of my journey as a novice MedFT working in a very unique and challenging community. I used my one-year clinical rotation to explore the many intricate relationships through the application of the subthemes revealed through my proverbs, made known in *The First Stroke* and "colorful" palette of BFST basics identified in *The Color Palette*. As a result, I was able to connect the dots with each of the relational contexts I was involved with while applying BFST through Titelman and Reed's (2019) *Variation of Differentiation and Family Reaction to Death*. While common factors were not presented throughout my academic journey, I believe that there are similarities amongst the MFT and MedFT modalities. Each have

their own languages, belonging to the various models/theories and respective concepts, from my perspective, each having the structure and ability to parallel one another. In chapter V, I will discuss the results in terms of the implications of these findings, as well as how they inform the clinical practice of working in the field of OMFS and directions for future research.

## **CHAPTER V: DISCUSSION, LIMITATIONS, AND IMPLICATIONS**

“There are all kinds of artists in the world. If people can combine the talent that they have inside of them with the hard work that it takes to develop it, they can become true artists. As work grows out of play, an attitude toward work grows with it – an attitude that may persist through our workaday life. That attitude can have a lot to do with how we accept challenges, how we cope with the failures, and whether we can find in the jobs we do, the fulfillment that makes working worthwhile, in and of itself.”

- Fred Rogers

The purpose of this dissertation was to paint a portrait of my journey as a novice MedFT working in a unique and challenging medical setting with HNC patients as observed through a BFST lens. In this chapter, I provide a discussion of my findings as they relate to my research questions. I also provide a discussion focused on the limitations of the study, implications for future research, and suggestions for MFTs, MedFT, and other mental, medical, and dental health professionals.

### **Discussion**

One concern along this journey was the lack in the literature to offer me a clearer path to the finish line. I found that the literature stresses the importance of using the biopsychosocial model to provide quality care, the consequences of not using it, and its ability to increase the overall cost-effectiveness in patient care (Muchnick, S., Davis, B., Getzinger, A., Rosenberg, A., & Weiss, M., 1993; Patterson, J., Bischoff, Scherger, J., & Grauf-Grounds, C., 1996; Hepworth, J, Gavazzi, S., Adlin, M., &

Miller, W., 1988; Brucker, P., Faulkner, R., Baptist, J., Grames, H., Beckham, L., Walsh, S., & Willert, A., 2007; Mendenhall, T., Lamson, A., Hodgson, J., & Baird, M., 2018). Further literature identified different types of post-graduate clinical sites available to students who want to gain experience in field. This literature also identified what the ideal process is thought to be, how the interns/students grow, what students' needs seem to be, what development looks like, and what is lacking in the education process to produce quality MedFT's, as well as the inclusion of larger systems in patient care (Muchnick, S., Davis, B., Getzinger, A., et al., 1993; Patterson, J., Bischoff, Scherger, J., & Grauf-Grounds, C., 1996; Gawinski, B., Edwards, T., & Speice, J., 1999; Mendenhall, T., Lamson, A., Hodgson, J., & Baird, M., 2018). Other literature looks at MedFT with more of a modernist/linear approach. While it promotes the benefits of bringing various medical professionals together for the best inclusive patient care, they do not include the patient and/or the family as part of the medical process (Dutkiewicz-Częścik, K., 2014). None provided a more in depth look at the therapist in such an environment. I did learn that the position of a "dental therapist" is not one of a mental health therapeutic stance but rather someone that can perform basic dental tasks, from injections to sutures post procedure. This offers patients the opportunity to receive more cost-effective patient care as long as the dentist is not involved in the process of the treatment received, such as working with the hygienist during routine cleanings, or providing simple restorative care (Radcliffe., E., Ghotane, S., Harrison, V., Gallagher, J, 2017).

Traditionally, a lack in literature can create many challenges when conducting research. This gap provided an opportunity for an exploration from a unique perspective as I was able to explore my work from a blank canvas. This journey was not without

many challenges, and fortunately no canvases were injured in this process. With time against me, the re-introduction to BFST allowed me to take my autoethnographic study to a new level once again, turning obstacles into opportunities. Additionally, the BFST lens allowed me to take my beliefs from a “black and white” perspective and add a bit of “hypothetical color” through the use of Bowen’s eight concepts.

I was able to I develop additional proverbs to assist in my process, thanks to Chang’s personal memory data collecting writing exercises. The additional themes developed, e.g.: ride the bus, don’t drive the bus, don’t push the bus, don’t take the bus hostage; all behavior makes sense in context; the easiest person to change in the therapy room is a therapist; what did the client hire you for? if they hired you wash the windows, don’t sand the floor; and when in doubt, summarize. These themes are based on proverbs that through the years have influence my work as a licensed psychotherapist. Fortunately, their flexibility was extremely helpful to this process, particularly as they were helpful for exploring my differentiation of self.

### **Riding the bus...**

This concept was introduced to me at the beginning of my master’s program by Dr. Annalynn Schooley. Her creativity and passion for the profession have helped to inform me as a therapist. Her “Schooleyisms,” as we called them, were simple suggestions to help beginning therapists to stay on task and not get caught up in content versus context. As systemic therapists, we are trained to look at the whole system. This proverb helped me learn how to just “be” with the client, his or her family, the residents, and attending faculty. In the instance of my clinical rotation, I had no road map from the literature to guide me through. It did not help that the didactic courses involved with the

certification of a MedFT provided little to no contribution as to how to enter such a difficult medical situation. When I find myself stuck, sometimes the easiest solution is to resort back to the basics.

For several months, I watched how the residents entered the room. I watched how they performed introductions, often it was a quick glance around the room, not always fully introducing everyone in the room. I watched how they positioned themselves in the room. I watched their mannerisms, how they eagerly and tirelessly, paid attention to the attending faculty's words and actions. As a full outsider, in the beginning, I was nervous entering the room with the team. I did not want to confuse anyone, I wanted to help them understand and learn about people like me and what a medical family therapist had to offer. My hope was to help them understand that as a licensed psychotherapist, I was there to learn about a cohort that I had only read about in articles and books. For such a "neglected population" I wanted to see how people like me can be helpful and work with practitioners to benefit this group of people.

Until I had earned my place on the team, I needed to ride the bus. I needed to be present, but silent. I was not in a position to push myself on them. The last thing I wanted to do was to take their process hostage and force my collaborative healthcare euphemisms on them. I needed to watch to learn. I needed to be present in the room to learn their processes and see how I could be helpful in them, and to the team as a whole.

### **All behavior...**

This proverb ascribes to multiple concepts within BFST. First, the level of differentiation of self that a patient and or caregiver could be operating from might lend itself to the "lower end" of the Differentiation of Self Scale. Gilbert, (2004) shared that,

“At the lower end of the scale, people are more emotionally fused in their relationships. They also show evidence of another type of fusion between their emotional (automatic) and intellectual functioning. That emotional/intellectual fusion may derive from the relationship fusions one grew up on.” Keeping in mind that the higher the anxiety the more likely their emotions are getting in the way of their ability to think clearly.

Adding disease to the equation made this task even more challenging. While not all outcomes are bad, not being able to camouflage major reconstructive surgery has the potential to increase the level of anxiety in the room. Titelman and Reed (2019) shared that “Anxiety has been described by Bowen as the automatic emotional reactivity to a real or imagined threat” (p. 215). With that said, what we may see as reckless behavior is in reality an unconscious reaction that instinctively lends itself to a fight or flight response based on the context of a given situation.

### **The easiest person to change...**

I believe that this applies in any situation, but it is not exclusive to therapists. Only we can account for ourselves. Entering such a unique community, I was not in a position to suggest what the patients, caregivers, office/clinical staff, residents, and or attending faculty were feeling or what they were thinking. As much as we would like to change the behavior or reaction of someone in the room, it is impossible and can create even more anxiety and chaos in the environment. It is much easier to look at yourself and identify what changes you can make to be different in or to the situation.

Not wanting to interrupt the system, I had to learn how to be the change in the room I wanted to see. As I stated before, I watched from the background to see how the interactions went in the flow of the system. I watched for cues such as, when the residents



discussed the case, to what extent did they discuss it, how much of this conversation happened with the patient and caregiver in the room, and how much of it occurred behind closed doors, out of hearing range of even the clinical assistants? The easiest way to do this was change where I stood, and to ask questions when I was unsure of things said in an effort to understand the implications. If I did not feel the question was important enough to ask in the moment, I would jot it down and follow-up with either one of the chief residents or the attending faculty when time permitted.

Once again, without any guidance on how to enter their system, I became a part of it. I worked alongside the clinical staff. I learned how to set up for various situations that presented throughout the day. This was my attempt to show the team I was not there to breeze through the process. I needed to let my actions speak for themselves. I wanted them to see someone eager to learn the ropes, the lingo, and the patient/caregiver interactions. How better to accomplish this than to change my own behaviors and actions?

**What did the client hire you for? If they hired you to wash the windows, don't sand the floor**

While this does not necessarily apply in this context of therapy, it really did apply to my behaviors and actions as to how well I was or was not received by the team. Technically, they did not “hire” me to do a job, I volunteered. In essence, I hired myself to learn as much as I could in that year with them.

I made myself as available as I possibly could. Learning the “lay of the land,” to me it was only natural to my being able to show them I was there for all the right reasons. When they needed me for unrelated tasks, I would make myself available. After all, it

was 5 long arduous months and two resident rotations before the team was more comfortable with me being there, let alone in the room with the team. It was up to me to make sure that the passing time was not wasted.

There was a time when they were short on assistants; as mentioned previously, there were only two of them. I would sanitize the rooms between patients and set them up accordingly. I can remember one time, we did not have any morning cancer patients, but two IV sedation cases with teenage females. With no spare females to set up the leads for the monitors or to be in the room for the procedure, I was quickly nominated for the job.

The assistant and the residents, all male, guided me on where to place the leads. In this instance, I was hired to be in the room to ensure the proper safety precautions since the entire team was male. At first, I was not so sure of my presence in the room... all that blood, or possible blood. I know that, in the past, I have had different reactions to the sight of blood. One, the fainting kind, to which I briefly panicked and worried what if I pass out? Then what? I remember talking to myself, almost like putting myself in a trance, I was needed. I needed to be ok with the blood. It was decided that I would sit in the room where I could see everything going on. I read articles on my iPad and hopefully kept low enough to not have to worry about seeing too much blood.

They had barely started the procedure when the young lady was showing some serious fear and anxiety to remove her third molars (aka wisdom teeth). She started to cry. As a mother, it was difficult for me to just leave her be. I remember asking permission from the resident performing the procedure if I could approach and see if I could help to calm her. Not sure how this was going to go, he gave me the go ahead. I positioned myself where she could see me, and I softly spoke her name. She reached out

to me and pulled me closer by my hand. Not knowing what to do, I asked her if she would like to hold my hand and she nodded a gentle yes. Once again, I repositioned myself so that I would not be in the way of the assistant or the resident and she held my hand, a perfect stranger. I could feel the trust she had just placed in me. It was important for me to remain calm so that she could remain calm. I did not want my fear of blood to interfere with the interaction this young lady required.

When the procedure was done, and I removed all the leads from the markers, she thanked me. I went to bring her mother back to the room and the young lady referred to me as an angel in the room, admitting that she was very scared when they got started but I was her gift from God to get through it. This could have been the anesthesia talking, but I was happy to be there to help. Had I not been there, they may have had to reschedule the procedure. Also, this provided the team an opportunity to see a little of my work, regardless of how small. Fortunately, what I was hired for transformed as needed.

I was able to show the team, once again, that I was there for all the right reasons. I was eligible and capable of being hired and could be trusted with their patient base. This was not the only time I was asked to represent in the room as the only spare female. I believe that my being so flexible allowed me to gain more trust from the residents and attending, enforcing that I was there to learn just like the residents. They were diving in from the high dive into the deep end, while I was slowly entering from the shallow end and gently treading water, moving toward the deep end.

I was happy to be able to help anywhere I could. This helped me become a more interactive participant in the experience. Being a systemic thinker, it only made sense to

learn about the entire system and what better place to start than right in the middle of where it all happens?

### **Epiphanies**

My experience as an LMFT and a systemic practitioner has, in its own way, contributed to an evolutionary change in approaching interactions between doctor and patient (by adding the MedFT to the room's components). Artists like Picasso, whose introduction to African masks created an epiphany for him that resulted in a new form of art we know as Cubism, created works with the appearance of many pieces combined together to create a portrait. When the Impressionists realized that light changes the impression of objects on the eye, they created a new school of art. In a similar way, epiphanies captured in the many re-reviews of my work within the many relationships at the OMFS clinic housed in a local hospital opened a new door in the medical community for MedFTs to become a complimentary treatment team component.

### **Bowen Family Systems Theory**

It was through the implementation of BFST that I was able to truly connect the dots of my portrait. Throughout the didactic portion of this expedition, BFST was the one theory that did not resonate with me. I struggled to grasp the concepts and apply them to myself as an emotional system. Remembering the advanced class mentioned in the previous chapter, in an extended attempt to further my knowledge, I was one of the students that chose to take the class.

It was not until I was re-introduced to BFST that new life and a fresh perspective was given to my study. Once again, I was provided an opportunity to start over with a blank canvas. There was one caveat, I had to willing allow myself to become completely

vulnerable in the process. It was important for me to be honest with myself when applying Bowen's concepts through the use of Titelman and Reed's (2019) *Variation of Differentiation and Family Reaction to Death*.

As I read back through my writing exercises and the details I remembered from the many interactions, I saw that at times I thought I was functioning higher on the scale of differentiation but I was more often on the lower side than I would care to admit. The purpose of the study was to notice times where my differentiation of self could have been different. This offered me the opportunity to be a "starting" point in future literature to painting a portrait for others entering the field who want to adventure into difficult medical situations.

Utilizing BFST allowed me the opportunity to be seen as Vinnie, a MedFT in training and separate from Vinnie, the dental implant coordinator. This original portrait showed my own differentiation of self and my own times of triangulation in a variety of relationships. Each one explored through the "color palette" of the eight concepts as intended through BFST.

### **Limitations**

Due to the nature of autoethnography, the experiences shared were limited to my experiences, which were then interpreted through my personal perceptions of them. Accordingly, this study was also limited to my perception of this portrait. Additionally, based on the self-reflexive nature of autoethnographic writing, the findings of this study reflected only my perceptions of experience and were interpreted through my cultural and professional assumptions.

## **Implications**

### **Future Research**

This study was conducted as an autoethnography to provide MedFTs and other dental, medical, and mental health professionals with an alternative perspective of entering a very difficult medical situation. This study was limited to my interpretations but there is a need for the voice and exploration of other therapeutic perspectives with regard to unique and challenging populations. A key component to this study was missing: the many voices of those I had the privilege of working with. In order to provide a more systemic interpretation of this experience working with HNC patients and the intricate systems involved, it is suggested that future researchers consider a collaborative autoethnography through which the experiences can be combined with those of other medical and dental professionals in order to better understand each other so that they can find ways to come together for the betterment of the patient experience.

How is it that, as professionals, we have the ability to get past life's mishaps, big and small, and still accomplish great things? Future research and exploration through a BFST lens would allow for a richer experience of the process from multiple perspectives and professional services in an effort to close the gap and work together towards a more cohesive and inclusive collaborative healthcare approach.

### **MFTs and Other Dental/Medical/Mental Health Professionals**

The process of data collection and analyses motivated unique and challenging experiences that occurred during this clinical rotation. Such implications serve as indications regarding the importance of systemic sensitivity when working with such a challenging environment where patients bring accelerated levels of anxiety to the picture.

All of the following implications pertain to experiences that led to gaining the trust of the residents and attending faculty for a novice MedFT in training who desires to work with such a challenging, yet deserving, population.

I would be remiss if I did not identify that we were all students on this journey. The residents, while working collaboratively with other medical and dental professionals, had not been introduced to the idea of including a mental health professional into the picture. This could be because most of them had first been introduced to Vinnie the dental implant coordinator, and not Vinnie the MedFT. Also, they knew nothing with regard to the world of MFT, let alone MedFT, which also may have made it difficult for them to differentiate between the two Vinnies.

There is no denying that triangles and one's differentiation are ubiquitous. They are natural processes that we have been a part of from the day we are born, long before we even know they exist. Reflecting back on times when my own personal life was falling apart, I remember I needed to manage a new level of personal anxiety. In early August that year, my father was placed on Hospice care. I carefully reviewed my emotional status with my supervisor. I assured her that if I were not comfortable with my work, I would be sure to reach out to her. This was not easy, as my father lived in Georgia. I went up before the actual semester began to help my family get things figured out as my stepmother could not do this alone. Leaving him was the most difficult part, as I was not sure if this was going to be the last time I would see my father alive. In my clinical rotation, I was working with families caught up in a similar situation, with some patients sick enough to die. It was crucial that I keep my personal emotional thinking separated from the professional environment I was working in.

While I managed my emotions to the best of my ability under the circumstances, the inclusion of the BFST helped me understand how I could manage to get through some very difficult times. At the tipping point of my clinical rotation, the residents were including me in conversations, they were asking me questions, and even the faculty began to include me in introductions in the room. I now had to find a way to mentally be two places at one time. The re-introduction to BFST helped me understand how I managed to make it through. I may not have been able to actively function from my intellectual system, but I was able to function above my emotional system.

It was once again that I saw that very first patient I talked about it. The elderly gentleman with the dry-erase board. He came back in with a new lesion on the side of what was left of his tongue. I went in to see how he was doing, and I learned that he had an updated scan, and the results did not look good. The team was discussing the possibility of performing a biopsy that day. There were no extra assistants that day. When they opted to perform the biopsy, I asked if he wanted me to stay in the room and he nodded with a gentle yes. My heart sank a little more that day. Fortunately, of all the residents available on site that day, the one I worked with this particular day was excellent with patients. At times, the residents are so focused on their work that they forget that there is a human being in the chair before them. I do not believe that this is intentional, but like many of us when learning new things, we are so focused on the process and not wanting to miss a step. This resident, fully aware of what was going on medically with the patient, was gentle with his words and actions. I asked the resident how I could be helpful and proceeded to prepare the needed items for the biopsy. The resident explained everything that he was going to do before he did it, really allowing the



patient to be a part of the process as much as possible. I remember jokingly offering to hold the patient's hand when they were getting ready to numb him for the procedure. He quickly accepted my offer and extended his hand toward mine. I remember the trust in his eyes while he looked at the resident and me. The three of us were so present in the room that day, each one well aware of the other and all together in these moments. When I processed it with my supervisor, I remember her complimenting me on being able to be there fully for both the patient and the resident. It really allowed me to be present for all of them, while continuing to be in check with my own realities.

On another occasion, the attending faculty member requested my presence for a patient consultation. The patient requested to meet with the faculty member, who I think may have known what it was about and felt the patient may need/want to talk to someone afterwards. I was totally caught off guard. Typically, at least one other resident would be in the room with us for "medical" conversations. The patient was seated in the reclining recovery chair, the faculty member sat in a chair to the patient's right and I on the left. I placed my hand on the chair the patient was seated in as I pulled my chair closer. This was not the first time I had engaged with this patient, who was not particularly old, maybe a few years older than me at the time. I remember being close enough to the patient to casually keep my hand on the arm of the chair, yet out of the patient's "space." He put his hand on mine as if trying to hold it and looked at the faculty member and said, "Give it to me straight, how much time do I have?" The doctor, in a stoic pose and voice, replied, "A year at most. It's time to start getting your things in order." He did offer a genuine pat on the shoulder, and softly apologized as he motioned me to stay behind and be with the patient.

I did not know what to do. My heart hurt for this man. I am not sure, but we may have shared a tear in those following moments. As I think about it, the faculty member positioned themselves as the “outer person,” leaving the patient and I to be the solid base of the triangle. By the end of this short interaction, I realized that the patient was holding my hand and the humanness in me held his hand back. While I am very sensitive to these things, surprisingly, I was able to hold myself together despite the fact that I had recently lost my father. Re-experiencing this interaction through BFST helped me see that the faculty member was working based on natural instinct and not from one of knowing, let alone being familiar with BFST.

I believe that exposure to BFST, even briefly, can be beneficial to assist in the process of someone that wants to work in such a challenging environment. Wanting to lend his or her skills and abilities to a unique community, one must be willing to be vulnerable with their own emotional system and recognize times that they can better manage an anxiety provoking situation.

### **Life Happens**

Like it or not, life happens. Some days it's smooth sailing and others, it is like adding the finishing touch to your painted portrait, only to discover that the color you selected was too watery and it proceeded to drip down through all the fine details you had previously poured yourself into. Some would look at this as a total disaster, while others might see the opportunity to give new meaning to the portrait.

What I did not originally understand was how I was able to give the appearance of functioning more towards the intellectual system after my fathers' passing. Was it because of my therapeutic training that emphasizes as therapists, we leave our personal

issues at the door? Was it that my supervisor, unknowingly to me, triangulated herself into the picture, helping me process my emotions more often than usual, creating that solid base of the triangle, sharing my fear and emotions so that I could finish what I started without interruption? Maybe a combination of both.

### **Future Directions for My Work**

In order to circulate the findings of this study to MFT, MedFT, and other dental, medical, and mental health professions, my primary objective is to publish this study. To further increase awareness about this information, I intend to present my findings at various national conferences. Just as important, I aim to provide training to MedFT as well as MFTs and other dental, medical, and mental health professionals that wish to work in such challenging and unique environments as an added resource.

Once again, I would like to believe that exposure to BFST, even briefly, could be beneficial to assist in the process of someone that wants to work in such a challenging environment. Not only understanding where your emotional process stems from, it can help one identify where they could make changes to be the best version of themselves, opening clearer access to his or her natural intellectual self. In essence, this would allow practitioners of all medical and mental health modalities the ability to work with challenging populations without adding to the anxiety in the room or leaving with the patients.

### **Conclusion**

With no map of literature to offer guidance, or even a starting point for this portrait, it was the personal memory data collection exercises and the eight concepts of BFST that helped create this portrait. Despite the fact that I naturally operate from an

MRI, Solution Focused therapeutic stance, it was the inclusion of BFST for the third time that I realized there is more to my emotional process than recursivity, circular causality, positive and negative feedback loops, and working toward change. Like they say, “third time’s a charm.” As an outsider, I was met with resistance from the team, but I believe it was because none of them knew how to implement my assistance, let alone how it would work out.

Through the process of conducting this study, I came to realize exactly how much my self-critical influences impaired my ability to see what I was actually doing right. I can say with confidence, when I got this location approved for my clinical rotation, we were all in a place of not knowing. It was a week by week joint venture and I believe that part of the success of my navigation was a result of my training as an MFT in learning how to ride the bus and make sense of behavior based on its context. Knowing that the only person in the room I could change was myself was beneficial and allowed me to radiate enough confidence to make me eligible for hire, even for odd jobs.

I am thankful for third chances. The third time I was introduced to BFST proved to be an invaluable charm by providing the missing piece necessary to cross the finish line. That, combined with the process of writing this study, was emotional at times, although unintended, through a self-reflexive aspect. Writing about each experience, reflecting on them, reading and re-reading and then applying them to the “color palette” in order to connect the dots, I came to the sad realization that I never fully grieved the loss of my brother, sister, father, or mother on this journey. More importantly, I came to realize that I do not always function from a higher differentiation of self and that’s ok. It is being able to recognize it and continue to grow from there that matters most.

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Your dissertation has provided new insight into the inclusion and assimilation of the Medical Family Therapist as a valued member of the Head and Neck Cancer Team. Your one year internship participating with the Nova Southeastern University College of Dental Medicine's Oral and Maxillofacial Surgical Department's Head and Neck Surgical team provided the opportunity for you to "Ride the Bus" and experience the journey of self-exploration channeling your personal emotional vulnerabilities and anxiety. It is interesting to note the imprint left behind from your input as a "Team Member" and the impact on residents, faculty, and patients. The residents and faculty were impressed with your ability to relate to patients and their caregivers in a more patient centered approach providing the sensitivity necessary to help patients and their care givers cope with the uncertainty about disruption to daily life, a diminished self and fear of return of the cancer. Although most teams have the availability of a social worker, and clinical psychologist to deal with psychosocial issues relating to the patient, the Medical Family Therapist expands that role to include family members and caregivers. The faculty and residents through your participation understood the uniqueness of the Medical Family Therapist to bridge an important gap and provide a conduit for patients to relate to their caregivers about how they feel or what they are going through. I encourage you to continue your passion expressed in your dissertation and publish helping to educate all parties of interest on the role of the Medical Family Therapist in supporting the emotional and psychological well-being of patients and their caregivers who experience the ordeals of Head and Neck Cancer treatment.

A handwritten signature in black ink, appearing to read "St. Kaltman", with a long horizontal line extending from the end of the signature.

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