



reimagine Medicine Episode 2: Not So Happy Holidays

Dr. Lifshitz: Welcome to the reimagine Medicine Podcast. As always, we look forward to delving into the topics that are shaping clinical care, medical research, medical education and challenging us to reimagine medicine. Each month, we bring together clinicians, researchers, educators, health care thought leaders and medical students to share experiences and ideas that are fueling their efforts. In this episode, we will focus on emotional wellness. I'm Dr. Jonny Lifshitz.

Dr. Brite: I'm Dr. Katie Brite

Dr. Lifshitz: We are faculty members at the University of Arizona College of Medicine - Phoenix. Thank you for joining us.

Dr. Brite: For many people, the holidays are associated with time spent with family and friends, creating memories, writing narratives of our lives. In this episode, titled Not So Happy Holidays, we are going to focus on the other side. Holidays can also bring stress, people are grieving, depression, anxiety, loneliness and many other emotional health challenges. We are so glad you're with us.

Narrator: The opinions expressed in this podcast are those of the hosts and their guests and do not represent the opinions of the University of Arizona College of Medicine - Phoenix or Banner Health. Do not use this podcast for medical advice. Instead, consult your personal family physician for medical care.

Dr. Lifshitz: Our guests today are Lizy Windsor and Dr. Kristen Ray. Ms. Windsor is a clinical simulation nurse in the University of Arizona College of Medicine - Phoenix's simulation center. Lizy has 26 years of experience working as a nurse in clinical settings. She has a master's in Nursing Education and recently started her doctorate of nursing practice program in Mental Health. She is also an active reservist in the US Air Force Reserve. Dr. Kristen Ray is a licensed professional counselor and doctor of behavioral health. She serves as the vice president of Behavioral Health at Bayless Integrated Healthcare. Dr. Ray has extensive expertise in integrated health care delivery, individual/family therapy, crisis intervention, program development and evaluation.

Dr. Brite: Thank you both so much for coming. I have a question for you, Lizy. During the holidays, people tend to focus on making things perfect. Running around and doing everything for their loved ones. The old adage, fake it until you make it. So much that they might ignore signs that they are struggling. As a nurse who has cared for a number of patients, what are some of the common symptoms that you've noticed, maybe some warning signs, behavioral cues or red flags that people should look for that they might be dismissing.



Windsor: So often, the classic symptoms of depression like prolonged sadness, lack of hope, or loss of interest in previously enjoyed activities, but sometimes there are also subtle symptoms. A common misconception in people is that they need to be weepy or sad to be diagnosed with depression, but however, sometimes these changes can come in as changes in sleep pattern, some eating habits that change, and feeling fatigued. In my practice, I've also seen patients experiencing irritability, hostility, anger and being sensitive to rejection. Some of the subtle signs of depression patients have said is that they have experienced slowing of thinking, forgetfulness, or difficulty making decisions. Sometimes, they overthink situations and events and they get caught in that loop of negative thinking. So, those are typically some of the symptoms that you see in patients.

Dr. Lifshitz: Lizy, those symptoms uniquely define us as being human almost. My concern is that a physician or any other health care provider sees a patient for such a short period of time and many of the symptoms that you are describing are expressed over longer periods of time. What advice do you have to clinicians or future clinicians about how to either draw out those symptoms or gain confidence in the patients in terms of describing those symptoms that might be identified as depression or other types of behavioral health conditions?

Windsor: The symptoms that I mentioned is, as you correctly said, it's not like a day or two and they can just snap out of it. It kind of lasts for weeks on end. Usually we say that patients, we typically teach the families to identify those and usually we teach the patients to identify those symptoms in themselves. Normally, we educate clinicians to be able to be looking out for those symptoms and ask and probe the patients when they see them or interview them.

Dr. Brite: That's great. Just to follow-up a little bit. I wanted to talk a little about triggers for depression. I think there is sort of possibly a misconception that there has to be a specific trigger for depression and sometimes there might be, but can you talk a little more about that. Specifically, we know there is a neurochemical imbalance in the brain with depression that patients really don't have control over. I was hoping that you could just expand on that a little bit for our listeners.

Windsor: Yeah, typically depression doesn't always need a trigger. Sadness can come without any kind of unpleasant event or warning, but often times, it can be preceded by some triggers and some of them are major life changes such as a move, graduation, or a new job. Often times, patients say that they are going through financial troubles including bankruptcy or debt. There are often relationship issues such as tension in the family, there may be a break up or a divorce of their own or their loved ones. Often times, depression can be followed with the death of a loved one or even women talk about having depression, called postpartum depression, after giving birth to a child. So even though it's a joyful event, women do go through that. Often times, patients and families move away and they feel loneliness and that can be a



trigger for depression. Of course, we all have stress and sometimes, it depends on our coping mechanism and how we deal with it and sometimes, that excessive stress can lead to triggers in depression.

Dr. Lifshitz: Without question. And learning that so many different people in different walks of life are susceptible if not even in expressing symptoms or signs of depression. I'm assuming this is a self-evident question in terms are there enough providers to deal with the number of people who have depression?

Windsor: We noticed that they did not have enough providers to get help from so that was always a concern because we hear of successful suicides being attempted in the troops. The 22 partake campaign came from that so all that instigated me to go back and get my education so that I can be one of those providers to fill some of that shortage.

Dr. Brite: Thank you. So you have given some examples of when maybe a life stressor or a situation could be triggering depression. For some people they don't have a trigger, they might just be depressed, because we know it's a neuro-chemical imbalance. Either way, what advice would you encourage those who might be feeling depression and symptoms of depression to take the first step toward getting help.

Windsor: I would suggest that they talk to their family and friends and also to just learn about depression and learn those signs and symptoms and be able to recognize them in themselves and in close family members or friends.

Dr. Lifshitz: Thank you so much. That helps to highlight the scope of the problem of depression. Dr. Ray, this is where you work. This is at the intersection of primary care as well as the social structure that we all live in. Do you have any suggestions on how to identify these symptoms or even build trust with others, especially in a way where timing is a critical element.

Dr. Ray: I think building trust quickly and at the right time with our patients is imperative to good care and can really impact our patient's health. About 80 percent of people with a behavioral health disorder will visit a primary care provider at least once a year so we are seeing these patients in primary care clinics. I think that there are definitely some skills that work better than others in building trust. As we know, changing health behaviors in general, is very complicated and can take a long time. One of the skills I think that I'd choose and one of the most important is that providers are able to have empathy and remain non-judgemental while working with patients. Especially with patients who might have difficulty adhering to treatment, or their treatment plan or to their medication regimen. I think that goes a long way in building trust. In addition, communication is often really important in building trust. I think that communicating often and even over communicating in health care, I don't think is a real thing. I think that you can communicate a lot of things over and over again and it sounds like we are repeating



ourselves to our patients, but I think repeating important steps people can take in their health care is really necessary to build that trust, because patients will take away different messages at different times.

Dr. Brite: Excellent. Thank you. So Dr. Ray, as you know, as a primary care provider I know that I'm often first contact for patients who are having behavioral health challenges. Can you tell me what your advice would be for practicing clinicians to be sensitive to these signs, remember to screen, include that as part of their practice so that they are comfortable detecting depression and anxiety so we can capture people early.

Dr. Ray: Absolutely. I think many providers have some anxiety around screening because they don't know what to do with a positive screen. I think that especially with a depression screening, if patients report feeling suicidal or are unable to contract for safety before leaving the clinic, a lot of providers don't know what to do in that situation. So, I think having a plan in place for what to do in that situation can go a long way in helping providers feel more comfortable. I think there is also a myth with being really direct and asking patients questions about whether or not they feel suicidal will contribute to their decompensation or increase their likelihood of committing suicide. So, I think understanding that and being direct with patients, actually builds trust and can go a long way into finding the right treatment modality for that patient and can really help providers feel more comfortable as well.

Dr. Lifshitz: Dr. Ray, before we get into the way in which Bayless Integrated Healthcare puts together their health care system. Can you share with us a knowledge nugget? Basically, a couple key phrases you might use to start one of these conversations that our listeners can take back with them.

Dr. Ray: Sure. One of the phrases I like to use very frequently, we are able to use this in a variety of health situations or health problems, would be something like this: The last couple of times I've seen you, it seems like there has been a lot of stress affecting you or your family and I'm really worried about you. I have a colleague who specializes in just this situation or helping others who are experiencing similar stress. Would you be open to talking with this person?

Dr. Lifshitz: That definitely gets to the idea of having listened and then repeating back to the patient.

Dr. Ray: It also normalizes that there are other people feeling that. I think often times, especially with depression and anxiety, people feel so alone in those disorders and so really validating and normalizing that it is an experience that other people feel, can really go a long way as well.

Dr. Brite: I'm so glad you mentioned that because I think that a lot of what we do is trying to destigmatize depression. It is so common and so prevalent and I think it's so important in health care for everyone to understand that it is so prevalent so that people don't feel alone. Can you expand a little bit on the topic



that Lizy brought up about how clinical depression is more about feeling sad, it can be in the absence of reason. Rather than being able to pinpoint a specific situation or a specific emotion.

Dr. Ray: Absolutely. I think it is very common for people to have a lot of guilt around feeling depressed or sad, especially if there is not a situation that initiates those feelings. A lot of people often compare themselves to other people in their lives that may have, as they deem, as more unfortunate circumstances, so they don't feel justified in having those feelings. I think it is interesting when, as professionals, we diagnosed depression that situation is not part of the actual diagnosing so we diagnose depression based on the symptoms the person experiences and that those symptoms last and are unrelenting for two weeks or more. I think when you combine those things that there really doesn't need to be a triggering event that leads to people feeling that way.

Dr. Brite: Great. So, many clinics and hospitals are starting to become integrated and incorporate the physical and mental health care together. I was wondering if you could expand a little bit since Bayless Integrated Healthcare is ahead of the curve on this. I know, as a primary care provider, I'm fortunate to be in this setting and have colleagues like you at my fingertips, but for our listeners, can you explain what this integrated model looks like and also, why you think it has impacted your ability to care or how it has impacted your ability to care for patients?

Dr. Ray: Sure. I'd love to expand on that by using a story about a patient, because I think it really drives home the impact in a very personal way. One of my favorite patients to talk about is a teenager that I worked with several years ago. She was going to see her pediatrician for her annual visit. The pediatrician did the annual screening for depression and it was a positive screen. He did a warm hand off and introduced me to the patient. When I delved in and asked further follow-up questions about the depression, it turned out she was feeling suicidal that day and met criteria for a major depression episode. We began her treatment and I saw her weekly and we are able to do some therapy around depressive symptoms. One of the interesting things about working with her is that she originally came into the pediatrician because she met criteria for obesity, asthma, and was pre-diabetic. So she had some pretty substantial physical ailments as a teenager. After we were able to work on her depression, what we really noticed that she was exercising more, she was hanging out with her friends more, she was more in contact with her mom and her other relatives. She began to take her medication as prescribed, her asthma symptoms went down, she started to lose weight and she no longer met the criteria for pre-diabetes.

Dr. Lifshitz: You've done an excellent job of stealing my next question, which was about describing a success story about how integrated health care was able to achieve a success and describe very cleanly how it's not just the patient, it's the patients extended support network and the health care provider team around them.



Dr. Brite: Switching gears here, as we just have a few more seconds with you. I recently read your article that you had published in the Foothills News on seasonal affective disorder. In your opinion, do you think the holiday blues could be significant enough for patients to actually not be motivated or avoid seeking help with a health professional?

Dr. Ray: Absolutely. Seasonal depression, which is also known as seasonal affective disorder or SAD, affects about 3 million people per year and a lot of people don't seek treatment because they believe it will pass, which in some ways is true because if it is seasonal it comes and goes. I think a lot of patients miss is that it reoccurs, so the next season they will tend to feel the same way again. I think as providers, if we continue to screen even though we also believe it will pass because it's a seasonal disorder, and offer help and connection, people will be able to connect with care as needed.

Dr. Lifshitz: That is an excellent point. A thought that just occurred to me is the fact that holiday times add the additional stresses and additional duties to our normal daily life. One of the last things we should do is actively avoid seeking help at this time of year. I just wanted to say, thank you to both of you for sharing your insights on recognizing and beginning to intervene regarding mental health. It has been a pleasure talking with you. I wish we could go on, but we have to take a break. After the break, we will continue with our next guests.

Narrator: Dr. Lifshitz serves as the director of the Translational Neurotrauma Research Program, which is a joint venture through Barrow Neurological Institute at Phoenix Children's Hospital, Department of Child Health at the University of Arizona College of Medicine - Phoenix and the Phoenix Veterans Affairs Health Care System. Dr. Katie Brite is the chair of the curriculum committee and co-director of the Family, Community and Preventive Medicine clerkship at the University of Arizona College of Medicine - Phoenix placing students with community clinical partners all across the state. She is a family physician and the vice president of primary care services at Bayless Integrated Healthcare.

Dr. Brite: Welcome back to the reimagine Medicine Podcast. Dr. Touch is a clinical psychologist and an assistant professor in the Departments of Psychiatry and Family, Community and Preventive Medicine here at the UA College of Medicine - Phoenix. She also serves as the director of the Behavioral and Social Sciences Health Theme, which is spread across the four-year MD curriculum to help students learn to understand and heal the whole person as early as year one.

Dr. Lifshitz: Welcome Dr. Touch. We are happy to have you and extend the conversation that we have on emotional health for this particular podcast. As Katie said, you are directing the behavioral and social sciences theme for our medical students in order to make them the best medical students that they can be. The idea behind this is to help those students understand and address barriers to healthy living and



medical adherence so that they can broaden their thinking about how social, family and psychological factors might impact health and disease, not only for patients, but for themselves. So the question that I have is how does this shape the care that our students and alumni are able to provide to patients understanding this theme? How does it help them to recognize issues in their patients and provide the appropriate treatment?

Dr. Touch: Thanks again for including me in this so early in the reimagine Medicine Podcast. I believe that being able to focus on behavioral health will really take the hippocratic oath from a pledge to living in action. So we are teaching skills to the medical students as well as knowledge-base about the psychological factors that impact health and healthy living and those barriers to being healthier. I think we teach skills that have to do with how well they can motivate clients and patients because I think we do some patient education, but that doesn't always translate into action or behavior change. So, we are teaching skills as well as attitudes and knowledge that I hope will launch students well into the next 20 years of their practice.

Dr. Brite: Wonderful. Here at the college we are often reiterating to our students that in order to take care of others, you need to take care of yourself. And this is not only true for physicians, but for teachers and parents. Really anyone, especially in the business of taking care of others. Sometimes they let their own health go by the wayside. So, How would you recommend overcoming the stigma surrounding behavioral health to encourage people to recognize when they themselves might be neglecting their behavioral health and struggling to recognize it and seek care. How would you recommend doing that?

Dr. Touch: I think people, especially here at the medical school, do really well with the kinds of self-care like exercise, eating healthy, but when it comes to emotions, we've kind of learned how to manage, suppress and distract ourselves from the emotions that we tend to think are negative. But I do think that they accumulate and of course, people know about anxiety related to exams. They may be able to sense in their fellow students and their friends that something is wrong and that they kind of in a patterned way, keep pushing off their emotions or putting them down. I think friends can probably help each other if they are willing to take that courageous leap and ask if someone is really doing okay or if they need some help and support. I do think that friends have a big play in that. I do think that we do have a culture of normalizing how we can cope with stress in some, maybe not great ways like maybe drinking, or again avoiding and denying. I think when people reach out with other alternatives, anything from being out with nature, being together and socializing in a way that actually gets to the heart on what's going on in people's lives, I think that is helpful.

Dr. Lifshitz: I really like that idea of encouraging our students to get together outside of official duties so to speak. Get out and either volunteer in the community or pursue a passion with a like-minded student. With that being said, I would like to pick your brain for a knowledge nugget. A knowledge nugget is a



phrase or a starter conversation. Do you have a skill that you try to present or share with medical students to help start these conversations that we can share with our listeners?

Dr. Touch: I do think that people being honest about their own struggles is a good way to start because it sort of opens an intimate conversation that we don't often have. So if people have had personal challenges, obviously they may not want to reveal everything about that, but they might say what they tried. I think the other is noticing some behaviors that people might try to deny or minimize. So with a very non-judgmental, caring perspective to say, you know, I know that you haven't been able to get up very easily in the morning or you've been skipping study groups. So noticing patterned behavior and then following that with, is there anything that I can do for you? Is there someone else who maybe knows how to help with sleep problems? Kind of identify some symptoms like we would do with patients with other illnesses. Just put it out there as an invitation.

Dr. Lifshitz: It really gets back to that idea of an honest conversation between individuals.

Dr. Touch: Right.

Dr. Brite: I wanted to spin off that a little bit as a former med student and now a primary care physician, I know that when I was in med school, this is true, I felt for the first six weeks that I was never going to make it. I thought everyone else was doing just fine, but come to find out, not everyone was doing fine, we just all were doing the fake it until you make it thing and trying to figure out how to do that. So I am so glad that it is pretty evident to the students that they do need help, I think talking to the students they know where to go. But can you expand on that a little bit if students do decide that hey this is a little much.

Dr. Touch: Well there are a lot of invitations from student affairs and we have two psychologists as well as the ASU counseling center downtown. So students actually have accessibility to psychologists and licensed professionals really that they can talk with on a brief and longer term basis. I think some people do have insurance and they may be able to use that for other counseling or even support group kinds of things. I know that time is really challenging, that's one of the barriers. But there are also things like telemedicine, tele-mental health, so people could use some of those resources. Kind of 24-hours a day they may be able to find someone who is licensed, credentialed and willing to help.

Dr. Lifshitz: I know that from myself, as not as a medical student, but as a graduate student and a male, I'm not supposed to seek help. I'm not supposed to share my emotions. And that I may not have sought help for emotional issues if I had to come out of a specific room that someone might have seen me coming out of. And that's part of the stigma. Do you have any suggestions or ideas about how an institution, like the College of Medicine, might help to destigmatize emotional health.



Dr. Touch: One thing I think is, we tend to relate our private self to other people's public self. So we think, kind of like you were talking about Dr. Brite, when you see other people seeming to do so well, they aren't doing as well. Because privately, they are a different person. So I do think that sometimes asking a friend to go with a person to see a counselor kind of systematically having hours available earlier mornings or evenings or weekends, those kind of can be more private and confidential. I know sometimes there are different entrances or exits in counseling centers and now they are co-existing in medical practices, so I think that takes away the stigmatism as well.

Dr. Brite: For my next question, it's going to blend a couple of different thoughts. I'm always struck with how reluctant people from all walks of life are to talk about really, really any health care issue, but particularly the behavioral health and the emotional challenges they are having. So trying to destigmatize, just to spin off what Jonny just said, people realize hey your emotional health is a part of your health. It is a neurochemical imbalance and we have ways to help. Obviously, once a person has made the decision to seek help, that's great because they are in the system and we can start moving forward with a treatment program that works for them. What are some of the resources maybe for our listeners who might be identifying with some of the symptoms of anxiety, stress, or maybe depression to even where to start?

Dr. Touch: I think we have to think of primary care and tertiary care. A lot of people come in when they are in crisis. There is a text line, a crisis text line, people can text 741741, let me repeat that, 741741. A crisis counselor will have a text conversation. That is a national hotline and that's a good confidential way that people can use, but I do think that EAP, Employee Assistance Programs, if any of their parents or family members are employed, then that's a benefit. They can use those. Typically, there is no cost for that. So there are resources. The other thing is NAMI, the National Alliance on Mental Illness, and those are places that again have local chapters. Lots of support for patients and families. I think that doing some web searching and looking for clinics near them, or obviously word of mouth referrals would be excellent, but on-campus, there is a lot that we do for students especially to try to really promote wellness and mental health as a normal part of living.

Dr. Lifshitz: It is so exciting to hear that there are so many modalities that our students as well as anybody in the general public can seek in order to help them. To those of you that are listening to this podcast, if you or anyone you know, may be showing signs of anxiety, stress or depression, we are glad you tuned it. Please know that you are not alone and your primary care provider is ready to help. If you don't even know where to start, please start with resources provided on the website associated with this podcast.

Dr. Brite: It has been a pleasure having you join the conversation Dr. Touch and we appreciate you taking the time with us.



Dr. Touch: Thank you for inviting me.

Dr. Brite and Dr. Lifshitz: Thank you.

Dr. Brite: What an interesting conversation this has been. So many key takeaways.

Dr. Lifshitz: Without a doubt it has expanded my idea of what depression, anxiety, stress, the whole concept of emotional wellness might be where I came in thinking that depression might just be sadness or crying or being weepy.

Dr. Brite: Kind of the hollywood definition of depression of what we see, but really it was nice to see that our guests expanded upon that. Often, there is no weeping or sadness. It can be concentration, it can be sleep, it can be appetitie, things don't excite you like they used to anymore. It was really nice that they expanded upon that for our listeners.

Dr. Lifshitz: These emotions are actually all a part of life. They can be triggered by very specific events and then the responses might be perfectly normal. A person may need help for that, but if the response is beyond what is expected by the individual, then perhaps they need to seek help.

Dr. Brite: Absolutely. How we respond to life circumstances varies from one to the other, which again, has to deal with our neurochemical makeup. But the other thing I would like to reiterate is that there is often no life trigger and that is okay, too. Sometimes, I think people are always searching for a reason. Part of that guilty reason, why do I feel sad? I have a good life, nothing is happening to me, I have no reason to be sad. I loved the fact that Dr. Ray, Lizy and Dr. Touch kind of debunked that. You don't have to have a reason to be depressed.

Dr. Lifshitz: Correct. And if there is a depression that is surrounding your daily life, there are people around you that want to help you. As a culture though, we need to get over the idea that there is a stigma to mental health. Many people including myself were afraid to be judged. Why do I want to be judged? Sometimes it's nice to hide in the corner or not be pointed out for something specific and if it is something such as mental health, then it can be even more challenging to have to accept and reach out for help.

Dr. Brite: And that stigma is there for a reason. I love how Dr. Touch mentioned that even as recent as a few years ago we had separate entrances and waiting rooms for people who were there for psychiatric reasons or behavioral health challenges. We were part of the stigma issue, so it is nice that we are moving a good direction I hope to make people realize that their emotional health is part of your health. Emotional and physical health are intertwined so it is important that we make sure you are well both emotionally and physically. You can't separate the two.



Dr. Lifshitz: And knowing that there is not only the infrastructure, the entrances for these types of conditions that is changing, the fact the terminology is changing from mental illness to actually mental health. Everyone is interested in improving their mental health. And the fact that Dr. Touch is running the theme for the medical school that focuses on physician health, because if I'm going into seek health, I definitely want my physician to be in the best state possible to help me. Knowing that these students are getting that type of engagement and role playing as well as case studies early on is going to help them be better and help them help their patients as well.

Dr. Brite: We really do need to practice as clinicians and physicians practice what we preach to our patients, which is self care. I loved what Dr. Ray said and you said that we've changed to mental health from mental illness, but also sometimes we avoid that word altogether. Her nugget I found interesting. A lot of times when I am speaking to a patient, and she alluded to this, we just say things like oh my gosh I'm glad you brought that up because I happen to have a colleague who deals with exactly what you're going through, which could be insomnia. Avoiding jargon terms like mental or even behavioral health, if we could keep that out of the conversation because health is health and however we can help our patient become healthier from an emotional standpoint is the goal.

Dr. Lifshitz: And just connecting on a human level and starting that conversation and starting that conversation is really awkward. It's very easy for me to ask you where do you work out? How often do you work out? How much do you bench press, Katie? That type of thing. Or what are your dietary habits? But if I have to ask how you are feeling today or are you feeling satisfied in your job? These are more awkward and even deeper conversations. We got a lot of information about how people are not alone in this situation. They are definitely not alone. There is a large portion of the population that has signs and symptoms that would be equivalent or a sign to the emotional health conditions that we do have help for. Unfortunately, we also heard that many of these people don't have primary care provider. Perhaps one of the first steps is to reach out to others in their support groups.

Dr. Brite: I think the more we can be open about it and share our experiences, the more we can decrease that judgemental piece. As a primary care doctor, that part breaks my heart because I feel it is such a privilege to take care of someone, total, whole-person health including their emotional health. I always say, why would I not take care of someone from the neck up. It is an important part of their health and I feel like it is a privilege when someone does trust in me enough to discuss that. That is often a way to begin the process to help people find what's their best path for getting better emotionally as well.

Dr. Lifshitz: Without a doubt. Starting that conversation with a health care provider is a great way to start, but there is also the opportunity to start that with a trusted colleague, friend...



Dr. Brite: Support networks

Dr. Lifshitz: I really like the idea of going out and building your emotional health through perhaps a hike with somebody, where exhaustion might allow you to drop some of those barriers and bring out some of those emotional conversations. But not only that, if you are going to go on a hike together, we heard advice of going to seek help together. If a workplace or school provides help to create your own small group therapy where you feel more comfortable sharing or at least that you are not sharing in front of a stranger first, you are sharing with a friend. That just reiterates the fact that many of us are going to be comparing our private selves to everybody else's public life. We can all put on a show, but inside there is a lot of emotional turmoil that can use a variety of coping mechanisms and coping strategies.

Dr. Brite: We all have those separate, private lives. It is the fake it until we make it facade. That's great. It's a place to start. I think that is the bottomline. A hike and group support might help some people. Some people might need to seek more indepth help as far as maybe therapy, some people might need medication, everybody is different. So I think finding what each individual needs and hopefully, getting them motivated to take that first step.

Dr. Lifshitz: Motivation to take that first step, that is probably the summary of this particular podcast. We just need individuals to get started whether it is with their friends or with their coworkers.

Dr. Brite: I am really excited and I wanted to thank Lizy for joining the ranks because we have a shortage of providers in general, but especially in the behavioral health realm. So we are super excited she has chosen that path.

Dr. Lifshitz: As well as many of our students who may have chosen a similar path.

Dr. Brite: We hope so.

Dr. Lifshitz: In the next episode of reimagine Medicine, we will be talking with the founders of the CyberMed Summit. Dr. Jeff Tully and Dr. Christian Dameff. This summit, which is titled "Fighting Hackers: Health Care's Newest Threat." We are going to be talking about how malicious attacks can actually undermine medical care. We are going to look for ways in which we can develop solutions against that. In addition, Dr. Suzanne Schwartz will join the conversation from the FDA and you won't want to miss that. I went to the summit last year and it blew my mind.

Dr. Brite: I feel like our discussion today, Jonny, could go on and on and clearly behavioral health is something we are both passionate about, but unfortunately, our time is up for today. Brite out like a good night sleep.



Dr. Lifshitz: Lifshitz out like a well-functioning GI system.

Narrator: The reimagine Medicine Podcast is brought to you by the University of Arizona College of Medicine – Phoenix. Join us again as we highlight aspects of clinical care, education and research in an ongoing endeavor to reimagine Medicine. Our podcast team is Dr. Katie Brite, Dr. Jonny Lifshitz, Beth Smith and the media production team at the UA College of Medicine – Phoenix. Our theme song, Dungeon of Return Days, was written and recorded by Mid Air Machine. The song is accessible on freemusicarchive.org and used under the CCBOSA 4.0 license.