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EDITORIAL

# Training as a Psychiatrist When Having a Psychiatric Illness

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A medical student has decided to apply to psychiatry residency and reveals that he has previously been treated for a psychiatric illness. This experience has played an important part in his decision to pursue psychiatry, and the student asks his advisor if this information should be included in his personal statement.

A program director meets with a resident to discuss her recent decline in performance. The resident reports that the night float month has disturbed her sleep and that the death of a patient by suicide on her last rotation has brought up many personal issues. In this context, the resident discloses that she has a strong family history of a disorder and has developed psychiatric symptoms.

Much has been written in recent years on stress in medical school and residency and the risk of burnout or impairment due to mental illness. The new Common Program Requirements of the Accreditation Council for Graduate Medical Education (ACGME) have mandated an emphasis on educating residents and faculty on these risks and providing access to tools for self-screening and treatment when needed. Although psychiatric illnesses should be treated by employers and medical schools no differently from other medical illnesses, we suspect that stigma, bias, and anxiety continue to add to the challenges faced by students and residents. In this editorial, we discuss aspects of the limited literature on the topic of mental disorders among early career physicians and provide guidance for applicants, residents, and programs in navigating these complex challenges.

## Trainee and Program Concerns and Anxieties

Medical students with lived experience of mental illness who apply for residency training in psychiatry share many of the same concerns as their non-ill counterparts, yet they may wonder if their health condition disqualifies them from a career in psychiatry. Some may feel shame about their diagnosis and isolate themselves or perhaps not promote their accomplishments to the full in the residency application process. In addition, they may worry that their illness will make it impossible to fulfill the demands of the role as a psychiatrist. Alternatively, they may feel capable of performing the tasks of training but worry that they might be stigmatized or marginalized if their illness were to become known to others. In one early study with 1027 medical students, one of us (LWR) with others found that students were concerned that their supervisors would grade them more harshly if it were known that they suffered from an eating disorder, anxiety, depression, or alcohol- or drug-related health conditions [20]. The students in this study also worried that their academic status in medical school would be jeopardized if the Dean of Students Office learned that they had such a condition.

In this issue of the journal, Parry and colleagues [14] report on a review of residents seen at a state physician health plan. They found that the percentage of residents who presented voluntarily was lower than for attending physicians. They argue that this finding suggests that residents, despite their documented high rates of stress and depression, are deterred from seeking care by scheduling challenges, concerns about privacy, and fears of negative impact on their license or

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academic standing. The authors offer valuable suggestions about improving education of residents and program directors around these critical issues.

A worry about becoming stigmatized because of a mental disorder is not an irrational fear. Even psychiatrists may harbor explicit or implicit bias towards mental illness [27]. One former psychiatry resident described feeling stigmatized when faculty suggested that she take a leave because she "was scaring other residents" [8]. Another psychiatrist reflected back on his bipolar disorder during residency and the internalized stigma and shame he felt [2]. An article on psychiatrists with bipolar disorder included this quote: "You could do a study (about physicians having mental illnesses) but there'd be no sample because nobody would agree to be interviewed" [26].

Trainees may also worry about "overidentification" with patients. There is a stereotype that people go into psychiatry in order to heal their own mental illness, as opposed to that of their patients. Cutler et al. [6] reported the results of interviews with 4th-year medical students and found that 21% believed that people went into psychiatry because they were "broken in their head" (p. 495). Others felt that a career in psychiatry would precipitate illness, with one student saying, "Working with 'crazies' will make you crazy" (p. 493). Some authors have raised the concern that identification with the pathology of patients is a unique stressor in psychiatry training that can increase the risk of psychiatric illness [3, 29]. Kathryn Kris [10], a long-time medical student mental health services provider, stated that identification with the patient was essential but that it must be balanced with identification as a physician: "Most students do not lose this balance. Their psychological defenses enable them to differentiate themselves from helpless patients" (p. 1434). Unfortunately, Kris did not specify how the student or advisor should determine if the balance is optimal or how to define overidentification.

In our view, it is much more common for residents to distance themselves from patients (perhaps from the anxiety that they could actually become such a "helpless patient") rather than to overidentify. On rare occasions, however, the following may occur: The resident may feel that no one else on the treatment team is capable of understanding the patient, or the resident may feel that greater self-disclosure of shared experiences or the addition of a social relationship may be desirable. These situations can be signs that the resident is losing balance. Clear supervision from the faculty and program director that focuses on the value of normative professional boundaries for patient and physician safety is crucial. Disclosure of one's illness experiences to patients is a boundary crossing that carries profound risks for both the clinician and the patient. It is not advisable for psychiatrists in training.

Alternatively, given the high rates of psychiatric disorders in the population (lifetime prevalence of 24%) and given that treatment is generally quite effective, having experienced a psychiatric disorder could enhance a physician's ability to provide efficacious treatment. So long as appropriate professional boundaries are maintained without overidentifying with patients, awareness of the experience of depression, anxiety, or other disorders may actually foster increased empathy, appreciation of coping strategies, and connection with patients. Indeed, there is probably a "therapeutic window" between overidentification that blurs boundaries and objective decision making and utilizing one's illness experiences to actually improve evidence- and experience-based decisions.

Residents themselves endorse the idea that personal experience with illness fosters empathy and compassion. In a study of 155 residents in primary and specialty field training at the University of New Mexico, one of us (LWR) with others found that residents agreed with the view that clinicians who themselves or whose loved ones have experienced serious health problems are more compassionate and that clinicians who had experienced significant pain are more likely to provide effective pain management to their patients [22]. One resident said, "I can appreciate how what may appear minor to a physician can be major to a patient. If you have never been ill you may not appreciate these subtleties" (p. 372). Another said, "As a patient about 10 years ago requiring minor, elective but inpatient surgery, I was very poorly informed about the operation, risks, and care afterwards. Since then I have always been very thoughtful and conscientious about explaining everything to patients" (p. 372). And a third resident stated, simply, "Gentle providers made me want to be gentle" (p. 372). Healers may use their personal health experiences to create a deeper empathetic relationship with their patients.

Nevertheless, program directors and faculty have their own set of concerns regarding residents with psychiatric illnesses. If the illness is grave enough, it may impair function and consequently lead to failures in demonstrating competencies and meeting licensing requirements. Programs are necessarily concerned with the safety of patients and will need to ensure that steps are taken to protect patients in these circumstances. These steps should be guided by the details of the graduate medical education (GME) institutions' impairment policies.

The program director will also be concerned for the safety and well-being of the ill resident, especially given the stresses that may occur during residency training. The rate of depression, for example, increases substantially when entering residency training [12]. It is an irony of current education systems in the USA that although medical students may have access on campus to excellent student mental health services, once they enter residency, there are no longer well-structured mental health systems geared towards their needs. Instead, the resident and program director may scramble to find ad hoc assessment and treatment by mental health providers who are willing to accept the resident's insurance (a significant challenge at times) and who are not in a role where they may become involved in evaluating the resident.

Finally, a significant literature articulates the program's concern that residents with psychiatric illness will not be able to complete the program. Many program directors worry that if residents experience a recurrence of a mental (or physical) disorder, it would be extremely disruptive to the program's milieu. When the residency workforce is limited in a program, a resident on medical leave may result in a large burden on the others in terms of call, coverage, and a shortage of a full cohort on many rotations.

## Impact of Psychiatric Illness on the Residency Application Process

Medical students are often concerned that they will hurt their application prospects by disclosing that they have had a psychiatric illness. Although programs cannot inquire about applicants' health status or history and applicants are not required to disclose this information, students may face a dilemma regarding how to account for any leaves of absence or academic struggles that were clearly related to exacerbations of psychiatric illness. Providing no explanation of a leave or other challenges can also raise concerns and leave programs with a fantasy of the worst-case scenario. Such anxieties can have a chilling effect on the willingness to seek treatment. Medical students may not avail themselves of counseling services when depressed or stressed or when suffering from burnout [4]. Students do not seek necessary care or preventive care due to confidentiality concerns and workload demands [19–21]. A reluctance to seek help for depression, for example, may be attributable to a concern about an impact on their competitiveness in being selected [5, 23, 28]. In a qualitative study at a UK medical school [5], students were concerned about the risk to their career prospects, but a few did express the hope that their illness and treatment might make them a better doctor.

In one study of attitudes at a large medical school [25], over 95% of medical students felt that it would be risky to reveal a history of depression on a residency application. Sadly, the students with a significant history of depression tended to feel there was more stigma than students with no or mild depression. They were more likely to think that a depressed student's opinions would be respected less, that a depressed student's coping skills would be viewed as inadequate, and that a depressed student would be seen by faculty as less able to handle responsibilities. This study did not distinguish among students on the basis of future specialty, so it is unclear whether interest in psychiatry as a career would mitigate the perceived stigma.

Are these student concerns justified? Very few studies are available. One study by Oppenheimer et al. [13] created hypothetical applicant profiles and found that program directors were less likely to recruit a student if the application included a history of counseling. However, this study is now over 30 years old and, we hope, may not reflect contemporary attitudes. In addition, we have reason to hope that psychiatry programs would be more accepting in this regard than other specialties. Nonetheless, meeting stigma in professional settings is still very possible, although it may vary considerably today depending on the diagnosis involved. As a thought experiment, consider how the reaction of the advisor in the vignettes at the start of the editorial might differ depending on which of the following psychiatric disorders the medical student reports: obsessive-compulsive disorder, panic disorder, attention-deficit/hyperactivity disorder, post-traumatic stress disorder, depression, substance use disorder, personality disorder, bipolar disorder, and schizophrenia.

A related concern among medical students might be revealing family members who have psychiatric disorders, lest the program see them as biologically risky for inclusion in a residency. Once again, the fear of being labeled as risky, either as someone who may develop a psychiatric disorder or one who may overreact due to family experiences, may be a strong consideration and dilemma for many medical students during application.

Some students, alternatively, may be eager to share their experience of illness because it has been a valuable and sometimes critical influence on their decision to become a psychiatrist. Some students may come to medical school with a preconception that psychiatrists have little to offer their patients and find that their clinical experiences as well as their own experience of treatment provide a dramatic contradiction of this idea. They may be grateful for the efficacy of psychiatric interventions and inspired by their own treating psychiatrists: "I knew how much good a psychiatrist could do and I wanted to do that for somebody else" [26]. Meeting with a psychiatrist who is effective, kind, and wise can be a transformative experience in sweeping away previous biases and bringing the possibility of a career in psychiatry to life.

So how might medical student advisors guide students regarding disclosure of psychiatric illness? There is no one right answer for all situations. Students should be told that, as in any employment situation, legal protections are available against discrimination on the basis of disability. As a result, interviewers should not inquire about a health condition that the student does not first offer as a topic for discussion. Medical students should only offer such a condition as a topic when they have processed their experience sufficiently so that their focus is now on caring for their future patients, as opposed to struggling to sustain their own recovery. On a concrete level, the interviewer hopes to see that applicants are not overwhelmed by emotion when discussing their illness and can articulate what they learned from the experience that may be relevant to future clinical work. Any discussion with the applicants should stay within the frame of an interview that focuses on assessment of competencies (knowledge base,

interpersonal skills, self-reflection, etc.) and where the personal history is relevant to motivations and educational/career goals.

In these circumstances, many psychiatry program directors will then appreciate the applicants' openness and self-awareness and see their illness as a source of sustained motivation and deepening empathy. Program directors know that many fine psychiatrists and other mental health professionals have lived with or recovered from psychiatric illness and had stellar careers. Their achievements may be partially because of, rather than in spite of, their illness and treatment, even if stigma still means that this positive impact is not always openly discussed. In addition, the experience of psychiatric illness can help break down the divide of "us and them" between patients and doctors, potentially ameliorate the marginalization that patients feel, and help clinicians empathize not just with patients' illnesses but also their ambivalence about seeking treatment.

If the applicants are still wrestling with the impact of their personal experience, however, this struggle can become apparent during the interview process. Although the residency program faculty is likely to be sympathetic and to believe that employers should not discriminate on the basis of psychiatric history [24], they may also have concerns. For example, they may question whether the applicants have fully understood their motivations for choosing psychiatry or wonder about the applicants' capacity to establish the boundaries of a professional self needed to be an effective psychiatrist. In this case, students might be well advised to keep their personal history private for the time being. Mock interviews at the students' home institution can be very valuable in helping to determine their readiness to discuss their personal psychiatric history.

## Impact of Psychiatric Illness During Residency Training

Some psychiatric illnesses are reactive to stress and may manifest or relapse during the demands of residency [9]. While much has been written about the general stresses of residency (e.g., fatigue and sleep disruption, frustrations from working with uncooperative or demanding patients, demoralization from feeling that efforts are not resulting in substantial patient improvements), psychiatry training has its own relatively unique set of stressors, including adversities associated with aggressive acts by patients towards residents and the suicide of a patient [11, 15, 16]. Loss of patients is a grave stressor for residents in many fields, but loss by suicide carries unique challenges for the physician [1, 15].

The question of the subsequent impact of psychiatric illness on training, however, is not a simple one. As noted earlier, program directors may be concerned about the resident's completion of the program. On the one hand, a national survey in 1989 [17] reported that 17% of resident dismissals were due to "serious psychological disturbance" (although this may be an underestimate since "irresponsible behavior or interpersonal problems" were a separate category and may have masked some illness). On the other hand, the 1976 paper "*The Disturbed and Disturbing Psychiatric Resident*" [7] distinguished between suffering from a diagnosed psychiatric illness ("disturbed") and behaviors concerning to faculty or staff ("disturbing"). The authors found that three quarters of residents in their sample with psychiatric illness and concerning behaviors were nonetheless able to successfully complete their residency. They also noted, "Some residents with substantial covert psychotic disorders are able to complete residency programs and function satisfactorily in their field" (p. 449). One was a man with a diagnosis of schizophrenia with auditory hallucinations, somatic and paranoid delusions, and feelings of unreality, who nonetheless was judged to be an outstanding resident and went on to become an eminent faculty member.

When a resident has a mental disorder, it is important for faculty members, including the program director, to maintain a boundary between an administrative/mentoring role and a clinical role. The faculty member's role includes collegial support and referral for assessment and treatment. It may be wise to refer for treatment if possible to a different institution or a highly qualified psychiatrist who is not a member of the resident's faculty. An important administrative and mentoring function of the program director is advising the resident on the relevant reporting requirements of the state licensing board. The program director is focused on making sure that the resident has the resources needed to maintain safety and recover from an illness and on keeping a boundary between these functions and the resident's actual treatment. Of course, in regions or communities with very few psychiatrists, if any, outside of the faculty, it may be necessary to be more flexible and manage the tensions of dual roles, especially in a crisis. It is sometimes useful for the program to provide a senior non-evaluative faculty member as a mentor and guide for the resident. At times, it might be perceived to be in the resident's best interests not to tell the full story of treatment to the program director. A mentor may serve as an academic consultant and may provide a safe place for the resident to receive guidance. In either case, program directors should make it clear to the resident that information about illness is private and it will remain up to the resident to decide what to share with peers and faculty.

The program should remain focused on behavior and the ability to perform the functions of resident role, rather than on diagnostic issues. If attainment of certain knowledge, skills, or behaviors is below expectations due to an illness of any kind, an individual educational plan can be useful as a means to ensure that milestones are met and in order to graduate. Programs should make clear to the resident that no diagnosis

automatically disqualifies a physician from being a successful psychiatrist. Additionally, whether the underlying illness is addiction, depression, bipolar disorder, multiple sclerosis, seizure disorder, recurring pneumonia, ulcerative colitis, and so on, programs should make it clear that being a physician does not come with the expectation that illness will not occur or will not relapse. Any kind of illness, whether categorized as psychiatric, neurologic, or physical, can lead to an inability to perform duties, and therefore to “impairment.”

In many institutions, problems of resident performance will lead to a very important fork in the road—whether to apply disciplinary and remediation policies or to understand the problems as illness related and to apply impairment and well-being policies. The relation between these two different frameworks can be complicated and require consultation and guidance from the GME office and the Designated Institutional Officer at the program’s governing institution. Depending on the GME policies, a resident deemed to have an impairing illness may need to be followed by an institutional committee on impaired physicians or by a professional monitoring program administered by the state medical board. In some institutions, the Employee Assistance Program may be available to provide consultation to the resident in terms of performance and treatment options.

Residents with a psychiatric illness have responsibilities as well, which are no different from the responsibilities of physicians with any significant illness. The residents should be in treatment with a psychiatrist, avoiding any inclination towards self-treatment or “curbside” consults [18]. Residents are expected to monitor their health with their physician and be aware of signs of relapse, or, if necessary, to have a support system in place that will alert them to signs of recurrence. When ill, residents are expected to assess whether they can perform their duties, which very often requires consultation with their treating physicians. The program should fully support residents in decisions to take medical leave, both short- and long-term, in order to receive the treatment necessary to resume adequate function. Residents often worry about the acute impact of their medical leave on their peers’ workloads, so it is important to work with funding stakeholders to build some degree of margin into the residency schedule with a prepared plan for coverage for medical or familial leaves (as they should for any other part of the workforce, especially if entrusted with lifesaving duties). Often, training groups (T-groups) serve as a way for the class to support the resident in question and collaborate in managing gaps in the workload. Finally, residents are expected to adhere diligently to the treatment plans agreed upon with their physicians—this adherence is an aspect of the professionalism that is expected of all residents and graduated psychiatrists. On rare occasions, residents and their treating physicians will determine that work can be resumed but with some specific limitations or accommodations. These are the circumstances where the American with Disabilities Act is relevant, and specific guidance from the institution’s GME office and attorneys is generally indicated to ensure appropriate compliance.

Medical students and residents do not carry immunity to psychiatric illnesses. Having a mental disorder raises profound anxieties for the trainee and the program. The capacity to identify and consider these anxieties explicitly may help to decrease isolation and increase the possibility of good outcomes. Medical students, residents, and programs face challenges in navigating the residency application process, maintaining well-being during residency, and managing any times during training when illness impairs the resident’s function. More research is clearly needed on the impact of psychiatric illness on the application process and residency training in psychiatry.

Maintaining a consistent supportive stance towards impairment from any kind of illness can diminish the stigma that trainees fear, and that sometimes still exists. When managed responsibly, however, the experience of a psychiatric illness by a trainee in psychiatry can be a source of deepened empathy, insight into the difficulties of the patient role, motivation towards advocacy, and ultimately an opportunity to contribute to dissolving the unnecessary stigma of mental illness. Psychiatrists with their own experience of illness have been and will continue to be a vital part of our profession and very often a unique blessing to their patients.

## Compliance with Ethical Standards

**Disclosures** On behalf of all authors, the corresponding author states that there is no conflict of interest.

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