Psychiatry and mental health in the medical community

An interview with Dr. Sreelatha Varapran

Himani Dhar, Emily Dzongowski

ABSTRACT

Dr. Varapran completed medical school in Bangalore, India, then continued her medical training in Canada and finished her residency at Western University in psychiatry. Originally interested in otolaryngology, her exposure to psychiatry in Canada caused her to change tracks and to pursue psychiatry. She is currently a part of the Assessment Unit at Parkwood Institute Mental Health Care, has previously worked as Undergraduate Education Psychiatry Clerkship Coordinator, and is heavily involved in exposing the students of Schulich to psychiatry. We had the opportunity to talk to Dr. Varapran about psychiatry as a field, the psychiatry clerkship program, and about burnout in the medical community.

UWOMJ: When and why did you choose to pursue psychiatry?

When I did my medical training in India, I had no exposure to psychiatry and there was so much stigma around psychiatry at that time. We were all so scared to even go to a mental health clinic. I didn't really take any interest in it. When I came to Canada and I had to do a year of clerkship before getting into residency, I did six weeks of psychiatry. The preceptors you work with really make a difference, and I was lucky that I got two really good preceptors. I was exposed to how the psychiatrist can actually gain access to the deep part of a person. They get to know them so much better and that really fascinated me. When it came time for residency matching, I chose to pick psychiatry and I never looked back. There's never a dull day in psychiatry.

Tell us about the Assessment Unit at Parkwood Institute.

Typically, what happens is when someone needs an assessment, they go to the emergency room and are then admitted to Victoria Hospital where they get assessed. But I work in a tertiary care center. We don't get people from the emergency directly; we get people from the outlying areas. Also, anyone who is admitted and not getting better or who has questions regarding the diagnosis and treatment ends up coming to our Assessment Unit.

What kind of treatments and/or strategies do you implement in your practice?

It's a combination of things. I think in psychiatry you'll find that people have their own preferences. Some people like to use more biologically based treatments; some people more psychologically based, which also sometimes brings a bit of subjectivity into it. Medications are definitely a part of what I do but psychological interventions depend on what the patient needs. If it's emotional

dysregulation then [I would use] DBT Scales, or if there are other difficult and more challenging thought processes then I would use CBT approaches. It's a psychodynamic approach—getting to know the person more and trying to understand why they're suffering from depression, why they're suffering from anxiety. It helps with the formulation, it helps with understanding the patient better. Other approaches we have are ECT and TMS. So, I use a combination depending on a patient's needs.

Do you find that different cultural views influence a patient's perspective or preference for a specific treatment?

Yeah, for sure. Culture, I think, shapes who you are and your views about a lot of things, including your illness and especially mental illness. Some patients want biological treatments; they just want medication because they may feel like they "just want to be fixed." Some patients are completely against medications because they come from a very holistic kind of approach and they want to go natural. Sometimes when patients get very ill, they don't have much insight into what's going on, and I think some of our own beliefs—the culture and views that we carry—can become exaggerated when we become unwell. I try to incorporate what the patient is seeking and try to find a middle ground. Getting a chaplain involved and other disciplines involved helps to build that rapport and helps in their own recovery, too. [Patients] come with their own kind of views of what's causing mental illness or what treatments they need. So, it's very important to take those into consideration because again, you're not just treating a disease, you're treating a person and a person is not isolated. A person comes from a family, a community.

Previously you were the Undergraduate Education Psychiatry Clerkship Coordinator for University of Western Ontario. What originally drew you to that position?

For me, teaching came very naturally. When I was growing up as a child, I wanted to become a teacher. So, when I did my residency here, I was always engaged in teaching students. And then when I joined as faculty... So how it started was I was approached to do the [Patient-Centred Clinical Methods (PCCM)] coordinator role, so I took on that role and I really enjoyed running that course. I then got involved in the undergraduate education committee. I got more exposure to what medical students learn in medical school, like PCCM and [Patient-Centred Context, Integration and Application (PCCIA) course], and I got more involved in that. There were some changes happening within our undergraduate education committee, and I was asked if I could take over the role as the director. I really love it because you can do a lot more when you're in a leadership

position, and you can be an agent for change.

How does the psychiatry clerkship block compare/contrast with other clerkship blocks?

From our perspective, we don't feel like it's that different. As with any other field, we try to give the exposure, the bread and butter of that particular discipline. So, we try to provide [cases with] depression, anxiety, psychosis, suicide, risk assessment; you need to know those kinds of things. We try to offer that in a variety of settings—so inpatients or outpatients, acute care versus tertiary care. We try to balance that.

One thing about psychiatry that makes it different from other blocks is that it's not so service-based. It's not like we depend on students or residents to function. But a lot of disciplines collapse if there are no residents or students. We can manage. Most of the time I don't have students or residents working with me. So, when students come, we try to make it more of an educational experience for them.

Do you find that students face any difficulties when working within the psychiatry field compared to other disciplines?

Unlike other specialties, in psychiatry you get to hear a lot of difficult stories—things you may have never imagined can happen to someone, things that you may never have heard before. And you get to hear those things, and sometimes for students it can be a bit jarring. Depending on what's going on with the students themselves, it can be difficult. We always ask them to seek help if they feel like it's a bit too much. We've had students, when they've finished their psychiatry rotation, come forward and say, "It was too much, and I couldn't manage this." So, I think one should be aware that this field is not for everyone and if you're struggling, that's okay, too, and to come forward and talk to someone about that.

What are specific skills (if any) that students adopt in the psychiatry block that they implement into other blocks/fields?

One day I brought my daughter to work for Take Your Child to Work Day, and one thing she asked me is, "Is this all you do? You just talk to people!" And I thought that's something that's so key in psychiatry. Communication skills are very key, because that's all you keep doing. Also, the power of observation—it's almost paying attention to what's not being said—the nonverbal cues and affect changes, paying attention to those small details. I've also had a lot of students come up and say how blessed they feel or how privileged they feel or how grateful they feel for what they have, having seen other people who have suffered so much or who come from such horrendous backgrounds. So, a lot more self-reflection goes on, I feel, after you finish your psychiatry rotation, which improves your emotional intelligence. Those are some things that I feel would translate more into other disciplines.

What is your take on burnout within medical students?

There are some questions about burnout. That's definitely something that's happening for physicians, residents, and students. We get students who are a bit disillusioned after they do clerkship and are like, "This is not for me." I have students that have come and

told me that they don't want to apply for CaRMS residency, they don't think medicine is what they want to do anymore. And when you talk to them, it's like they had this vision of what medicine was all about, and then when they see social issues like patients having difficulty to cope, or you discharge someone and then they keep coming back—those kinds of issues that they are not really exposed to in preclerkship. There are real life issues that you see and systemic challenges that can happen within the hospital system, and those things can be sometimes a bit jarring for students. But for the question of "Does it happen?" we do see it happening. We definitely see it happening, and it comes up more and more when they finish the psychiatry rotation. I don't know if they feel more comfortable coming and talking to us or if they have struggled in rotations before, but in psychiatry they feel more that they can talk about these issues.

What do you think contributes to physician burnout?

Physician burnout is a huge topic in itself because there are so many factors that can go into it. If you look at the specialties, it's more specialties involved in emergency settings. Internal medicine, emergency, neurology; they all seem to be [at the] top. Dermatology and psychiatry are somewhere towards the bottom. Burnout itself is not even a diagnosis; it's a fluid thing. But the common themes are people feel emotionally distressed, a sense of isolation, of not accomplishing or getting anything done, and feeling stuck and alone. I think in medicine we are constantly being asked to do more with less. The workloads have gone up significantly yet resources have been cut back. There are definitely increased demands on time. There are many other factors: things like the team you're working on, the culture that's there. If everyone feels like it's not okay to talk about problems, then people will not talk about problems. There's almost a feeling that as a physician, you should be able to do this, so they keep pushing themselves through. There are issues related to bureaucracy—dealing with managerial stuff and feeling not being listened to or validated, or that people are not recognizing the efforts you're putting in. In addition to all that, what's going on in your personal life can definitely impact your work performance.

What's your advice to medical students as they move into clerkship and residency and learn to adjust to a high-intensity, real world environment?

Maybe be a little bit more realistic about your expectations. I think students sometimes come in and feel like medicine is glamorous and everyone is fixed, healed, or cured and that's not the case. People die; people don't get better. Maybe even getting more exposure before getting into clerkship through observerships. If something is upsetting you, speak up, and don't let one incident colour your entire view. Or focusing more on the negatives and filtering out the positives. Try to look at things from a more balanced view. And if they are struggling, know they can get help and seek out someone. You don't have to approach your preceptor and tell them you're struggling—get help in whatever avenue or form. Don't think you're alone. There are people out there to help you.