

Essay

A psychiatrist returning to work after a severe mental illness

Psychiatrists can tend to forget that we, as all human beings, can also develop severe mental disorders. This is the case for one author of this essay. After an episode of pericarditis, she had presented with a severe depressive disorder with psychotic symptoms (Cotard syndrome) for which she was admitted to hospital and treated by electroconvulsive therapy. She was on sick leave for almost 2 years. Initially, following the advice of her psychiatrists, she was admitted to hospital under an alias, but after several weeks, she decided to disclose what she was experiencing. In her recovery process—and as a creative way to fight against stigma—she wrote a book about her own lived experience of this severe mental illness, *L'intime étrangère: roman*. During this sick leave, in her psychiatric department, the topic became both taboo and a subject of gossip: nothing explicit was ever said about her condition in staff or doctor meetings—just that she was sick—but at the same time, people were gossiping about it, as if it was a shameful secret.

In this essay, we address the specific issue of the return to work of psychiatrists after a severe mental illness. We build our reflections on what happened to the co-author of this essay when she recovered and came back to work, and on how her colleagues acted upon and reacted to her return.

A favourable working environment based mostly on effective peer support with compassionate and empathetic colleagues is paramount to facilitating the return to work of employees with mental disorders. Instead of empathy and compassion, the colleagues of the co-author displayed embarrassment, distance, and coldness. With a few exceptions, no one asked her about her health, even less her mental health. Both the psychiatrists and psychologists of the department were distant and had fixed, stigmatising ideas regarding what she could and could not do at work, as we will outline below. A lack of support from colleagues was also described in a qualitative study of sick doctors returning to work, in which 18 of the 19 doctors were returning after a mental health or addiction problem, and for whom the lack of support was associated with increased feelings of shame and self-stigmatisation.

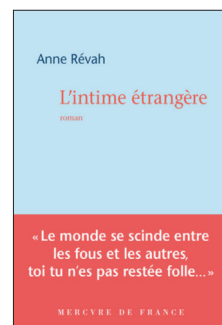
How should stigma from mental health professionals towards their own colleague be understood? They all have knowledge and literacy about mental disorders, and they all have a value-based practice with their patients to help them overcome stigma. We think it might be related to what Jaspers called the “un-understandability” of the psychotic experience, that is the elusiveness to empathic understanding. In other words, we consider that the psychiatrists and psychologists would have been more supportive and empathetic if their colleague had come

back after a cancer or a work-related mental disorder that they could relate to and rationalise. Similarly, we wonder if this colleague acted for them as an unbearable reflection of their own psychopathological risks, breaking the myth that somehow being a psychiatrist or a psychologist should magically protect them from severe mental disorders.

What about the exceptions? Why were a few professionals able to resist this workplace atmosphere and the shared cold attitude and instead build supportive and intersubjective daily interactions with the co-author? We first wondered whether this different attitude might be linked to those people having a less stigmatising explanatory internal model of mental illness, a model that would not blame the individual's character, such as biological explanations or a systemic approach to mental illness. But this theoretical approach does not fully explain the genuine and warm attitude of these few individuals. As naive as it might sound, the other co-author of this essay felt he could more easily relate with his colleague's experience since he was raised by a mother diagnosed with bipolar disorder. Therefore, we wondered whether a personal and familiar relationship with mental illness could better explain the attitude of these few colleagues. Indeed, such a relationship might have allowed these people to be more compassionate and empathetic, and this might have played a major role in their attitudes toward the co-author.

To help an employee successfully return to work after a severe mental illness, colleagues need to support the person and accommodate, at her own pace and convenience, her workload, schedule, and tasks, to increase a feeling of self-efficacy, which is an essential factor in the process of reintegration to work.

With the apparent intention of trying to protect her, the other doctors of the department only suggested limited tasks. They did not ask her how she envisioned to start working again; they chose for her what they let her do, namely one clinical staff meeting only with psychiatrists and psychologists. She understood that they wanted her first to reassure their other colleagues about her condition and recovery. Between the lines of these protective decisions, we could see the suspicion of her still being ill and that her return to work was seen as a risk for unbalancing the homeostasis of the existing system, almost a threat. The experience of the co-author of reintegrating at her workplace was rather a process of exclusion, with a paradoxical message of “it is for your own sake and for the team”. She has been told that certain colleagues did not dare to broach certain topics about patients—such as suicide—in front of her. And the only institutional response to these professionals' embarrassment was to



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For the **book on this co-author's experience** see Révah A. *L'intime étrangère: roman*. Mercure de France, 2021

For more on the **favourable aspects of the psychosocial work environment when returning to work** see *PLoS One* 2019; **14**: e0215354

For more on **self-stigmatisation in sick doctors returning to work** see *BMJ Open* 2012; **2**: e001776

For more on **self-efficacy on returning to work for employees with mental health problems** see *Work & Stress* 2010; **24**: 359–75

For more on the perspectives and challenges of lived experience of psychosis for research and care see *Curr Opin Psychiatry* 2023; 36: 194-99

exclude her from places where these professionals were not yet comfortable with her presence. In other words, instead of questioning this discomfort together and using it effectively to start a necessary dialogue about it, this institutional response shows that the priority was to neutralise any effect that the return to work of the co-author could have on her colleagues.

The matter of seeing patients on her own was not even raised, as if it was obvious that she should not see any, with, we guess, the same official purpose—to protect her, or the patients, or maybe both. These staggering precautions revealed another suspicion about her psychiatric skills and abilities. It was as if they considered that her psychotic experience made her lose her skills, her legitimacy, or even her identity as a psychiatrist, while in fact, experiencing a Cotard syndrome and recovering from it allowed her to gain some experiential knowledge. It is now commonly understood among psychiatrists that people with lived experience of psychosis can provide an understanding of psychosis that people with clinical experience and knowledge do not have, which is creating a paradigm shift in the field, promoting a democratic, co-constructive approach of knowledge with new professional positions such as expert patients and peer workers. Having experienced psychotic symptoms provided the co-author with an understanding of psychosis and therefore her patients that she, with her previous scientific knowledge and clinical experience, did not have.

If we imagine the same scene in oncology, everyone would consider it absurd to keep patients away from an oncologist coming back to work just because they had been through a cancer themselves. On the contrary, it would be most likely to be considered as a plus, which could enhance the quality of the doctor-patient relationship. So how, here in psychiatry, can this lack of consideration from peers of experiential knowledge be explained? We wonder whether, despite the politically correct discourse of most psychiatrists, there persists hidden the idea of “them versus us” in their minds, a sort of rabbit-duck image conundrum, with the cognitive impossibility to see both—the psychiatrist with her clinical knowledge and her experiential knowledge of psychotic symptoms—at the same time.

The first activity officially authorised for this co-author was a clinical staff meeting. During these meetings, the

psychiatrist returning to work felt she had to pass a sort of test, as if her colleagues were assessing and judging her psychiatric skills and knowledge. Clinical psychiatrists all know that many patients with severe psychiatric disorders, after a proper psychiatric assessment, can be considered incapable of performing their work and get a status of “inability to work”. This was not the case here. After more than 18 months of treatment, she was considered fit to return to work. Yet, this statement seemed worthless for the psychiatrists of her department, with the confusion that they have also knowledge in that matter, and that this knowledge becomes a power giving them the right to assess and judge by themselves if their colleague is fit or not.

There is here a loss of the statutory value of being a psychiatrist. Even if, officially, she had not lost her status, she felt that during these meeting she had to earn back her place, to prove that she was entitled to be here, almost as if she had to repass her diploma.

This lack of support, this partial exclusion, and this probatory loss of status show the extent to which psychiatric departments are not spared from the social stigmatisation of people with psychiatric disorders. Considering this psychiatric department within a systemic approach, all these aspects can be seen as symptoms of the anguish aroused within colleagues due to the disruption of the homeostasis caused by the return to work of a mentally ill but recovered psychiatrist. If it enabled a regaining of the homeostasis, it also hampered the failure of reintegration of this psychiatrist, becoming the “designated patient” of this institution. We could be tempted to recommend to psychiatrists in the same situation to make a pragmatic (and rather cynical) choice to lie and to hide (hence the alias during the inpatient treatment) and not to disclose their mental illness. Given the experience of the author, we would not blame anyone for making such a choice. Yet, even though this experience shows how much stigma must be changed, we would still recommend psychiatrists in the same situation to use their experience to fight against this stigma and to advocate for the right of psychiatrists to have mental disorders just like any other human beings, and the right to recover from such illness, receiving the support and help they deserve when returning to work, like any other human beings.

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