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1. How do you prepare yourself mentally before starting a particularly challenging therapy session?

Ans. Before a difficult session, I take a quiet moment to reset. Whatever may have happened earlier in my day has to remain outside the room because the person sitting in front of me deserves my full attention. I may review the case briefly, but I try not to enter with a fixed idea of how the session should unfold. Very often, the patient brings in something completely unexpected.

2. What is the most rewarding part of your everyday work, and what is the hardest?

Ans. The most rewarding moment is when someone begins to feel like themselves again. It may not be a dramatic breakthrough. Sometimes it is a patient saying, “I slept properly this week,” or, “I finally managed to leave the house.” Those small changes can represent an enormous amount of courage.

The hardest part is accepting that recovery cannot be rushed. As a doctor, you naturally want to relieve suffering, but you cannot do the emotional work on someone else’s behalf. You can guide them and stay beside them, but they have to walk through it themselves.

3. How do you protect yourself from emotional burnout or compassion fatigue when working with difficult cases?

Ans. I’ve learnt that caring deeply does not mean carrying every patient’s pain home with me. That boundary took time to develop.

I also remain aware of my own emotional responses. If a particular case is affecting me more than usual, I reflect on why rather than pretending it isn’t happening. Outside work, I make a conscious effort to have a life that is not centred entirely around illness or crisis. Otherwise, even the most committed professional can eventually become emotionally depleted.

4. How do you adapt when the usual therapeutic approach is not helping a patient?

Ans. My first response is not to assume that the patient is “resistant.” I ask myself whether I have understood the problem correctly and whether the treatment is genuinely suited to this individual.

Sometimes the pace needs to change. Sometimes another form of therapy is more appropriate, or medication needs to be reconsidered. There are also times when bringing in another professional is the most responsible decision. Treatment should never become an ego battle in which the doctor keeps repeating the same approach simply because it usually works.

5. How do you diagnose someone whose symptoms could fit several conditions, while avoiding unnecessary labels?

Psychiatric symptoms rarely arrive in perfectly separate boxes. Poor concentration, disturbed sleep or irritability can appear in many different conditions. They can also arise from physical illness, medication, substance use or a difficult period in someone’s life.

That is why I do not rush to attach a label after one conversation. I look at the person’s history and observe how the symptoms develop over time. A diagnosis should help us understand and treat the patient. It should never become the patient’s entire identity.

6. How do you know whether therapy is genuinely working?

I look beyond whether someone simply says, “I feel better.” I want to know whether life is becoming more manageable for them.

Are they coping differently when something goes wrong? Are their relationships changing? Can they recognise an unhealthy pattern before automatically repeating it? Progress is rarely a straight line, so an occasional bad week does not mean treatment has failed. Often, the real sign of improvement is that the person recovers from that bad week differently than they would have before.

7. How do you build trust with someone who is sceptical, resistant or attending therapy only because they were told to?

I don't try to force trust. If someone tells me they do not want to be there, I respect the honesty of that statement.

I usually begin by asking what would make the conversation useful for them—not for their family, their employer or whoever sent them. Once people realise they are not going to be judged or controlled, the resistance often softens. Trust develops when a patient consistently experiences you as truthful and respectful. It cannot be demanded through a professional title.

8. What led you towards your particular area of psychiatry, and how has that interest evolved during your career?

I was drawn to psychiatry because it sits at the meeting point of medicine and the deeply personal experience of being human. Two people can have similar symptoms and still require very different kinds of help.

Earlier in my career, I was naturally focused on identifying the illness and selecting the correct treatment. Experience taught me to pay much more attention to the life surrounding the illness. Understanding that context has shaped the way I practise today.

9. Has there been a case in which you felt you could not help the patient? What did it teach you?

Yes, and I think any honest clinician would say the same. There have been patients for whom the improvement was not what I had hoped for, despite sincere effort on both sides.

Those experiences are humbling. They taught me that professional confidence must always leave room for uncertainty. They also taught me that helping does not always mean curing. At times, helping may mean reducing the person's suffering or simply ensuring that they are not facing it entirely alone.

Naturally, I would never discuss the details of an individual case because confidentiality remains essential.

10. Looking back, what do you wish someone had told you honestly before you chose this profession?

I wish someone had told me how emotionally intimate this work can be. You may hear things that a patient has never said aloud to another person. Being trusted with that is a privilege, but it also carries weight.

I would also have liked a more realistic conversation about the early years of the profession. Training is long, confidence develops slowly, and financial stability may not come immediately. It is deeply meaningful work, but meaning does not automatically make it easy.

11. What is the one thing a student considering psychology or psychiatry should understand that a textbook will probably not teach them?

You need to be genuinely curious about people, including people whose behaviour you may find difficult to understand. Academic knowledge is essential, but patients will not always present themselves in the language of a textbook.

If you enter the profession because you want to give people answers, you may sometimes feel frustrated. If you enter it prepared to listen carefully and remain open to being surprised, you may become a very good clinician.

Most importantly, do not choose this field because you like the idea of being the person who “fixes” others. Choose it if you are willing to meet people at vulnerable points in their lives and treat that vulnerability with respect.