Teaching Psychodynamic Psychiatry to Students on General Medical Rotations

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Medical students' and physicians' training is oriented toward rapid retrieval of information and the development of those clinical skills needed to make immediate interventions. Medical students' education in the area of psychiatry is usually limited to a six- to eight-week rotation, where they are most often exposed to a view of mental function as a simple epiphenomenon of the activity of neurotransmitters.

To obtain a detailed psychosocial history that might give medical students some understanding of emotional reactions to illness is not part of their educational process. The biopsychosocial approach is given only lip service. A detailed psychosocial history is not regarded as important or necessary to understanding the illness of a person. Providing a meaningful experience of learning psychodynamic principles requires understanding the attitudes with which the medical students and residents come to their psychiatric rotation.

In this paper I will describe a method that has proven successful in integrating psychoanalytic concepts into the psychiatric education of medical students and internal medicine trainees. The method is evaluation of a medical case by the use of a simple psychoanalytic tripartite structural model and its resulting psychodynamics. The description of these pedagogic tools may appear simplistic to the psychologically sophisticated reader. Psychologically sophisticated minds, however, are not the intended audience of the method; students and medical residents are. In my experience, these methods have successfully started a process that allows the students to view mental functioning in a new, psychodynamic light.

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INTRODUCING KEY CONCEPTS

Clinical material and visual aids (some of which are reproduced as Figures 1–10) are the means by which the following concepts are introduced to the students:

- Existence of a structure of the mind.
- Components of that structure of the mind.
- Unconscious mentation.
- Individual variations.
- Developmental influences on these variations.
- Clinical evaluation of these variables.
- Effects on treatment decisions and outcome.

The tripartite model of ego, id, and superego, although questioned in psychoanalytic circles in recent years,[1] remains highly useful in this setting. It allows development of a framework in which mental illness can be seen as analogous to physical illness.

An introduction provides historical background about Freud, his postulation of a lawful mind, and the existence of unconscious mental components.[2] Freud began his career as a neurobiologist, citing Helmholtz as one of the major influences in his intellectual development.[3] Present-day students can still relate to Charcot's ideas about conversion and grasp Freud's realization that these may be reversible conditions that are attributable to some mechanism other than a degenerative process. It is then fruitful to introduce the students to the hypothesis of unconscious mentation as an aid to explaining and

filling the gaps in the patient's subjectively reported observations.

This elementary psychoanalytic model of the mind[4] (with modifications) is used as the basis of understanding of unconscious and conscious mental functions and the relationships between them (Figure 1).

This model of the mind, shaped for the students we are addressing, is based on the idea that humans are born with biological needs that initially must be met by a caretaker if the infant is to survive. These biological needs, sometimes called *instinctual drives* or simply *drives,* exert pressure for immediate satisfaction. Parental and environmental capacities and deliberate restrictions prohibit the satisfaction of these needs. Uncontrolled expression of needs a little later in development leads to disapproval and loss of parental love, resulting in painful experiences. These experiences are eventually integrated into the structure of the mind as conscience, designated by Freud as *superego,* which develops to accommodate to reality as well as to social prohibitions. Humans develop conscious and unconscious strategies, which are called *defenses,* to deal with conflict between needs, the limitations of realities, and the impositions of authority. These strategies reside within the structure of the mind that we refer to as *ego*. It is essential to convey that the ego is not a concrete structure, but a theoretical concept that allows an understanding of many spectra of behavior. A useful analogy is to describe ego activity as like that of a traffic controller at a busy airport terminal who evaluates departure priorities according to weather condition, traffic congestion, and safety. First and foremost, the ego has to judge reality so as to balance the need for gratification against the need for delay of gratification of basic wishes (Figures 2 and 3). It is essential to demonstrate that these conceptual ideas are applicable to the understanding of clinical problems.

It is usually necessary to repeat for psychoanalytic audiences (or readers) that the purpose of this pedagogic method is not to teach psychoanalytic theory to students of psychoanalysis, but rather to demonstrate to medical students and medical residents that their ability to take proper physicianly care of their patients is enhanced by their having a framework to understand the developmental and emotional personality factors that influence the onset, course, and outcome of illness. Just as in other applications of psychoanalytic understanding outside of the psychoanalytic situation proper, we are not trying to teach psychoanalysis, but trying to help other clinicians to do their work in a better and more satisfying way.

We can now consider case material, in which the gradations and variations of these forces can be seen to influence the clinical picture. The cases are sometimes presented by the student and sometimes demonstrated by myself using projected slides (some of which are reproduced as figures in this article). Case presentations are selected to allow the exploration of underlying psychopathology and elucidation of the pertinent mental functions.

The case material that follows represents a common clinical problem that can be an outcome of either noncompliance and impulsiveness or of strict morality and inflexibility: both cases illustrate failure of the ego to balance gratification, reality, and moral prohibitions in an adaptive manner.

A 47-year-old man was brought into the hospital with ascites secondary to liver failure. He had been abusing alcohol for 20 years and had never complied with any treatment for this difficulty. He was aware of the life-threatening condition and

FIGURE 1. Visual aid introducing concepts of conscious and unconscious mental functions.

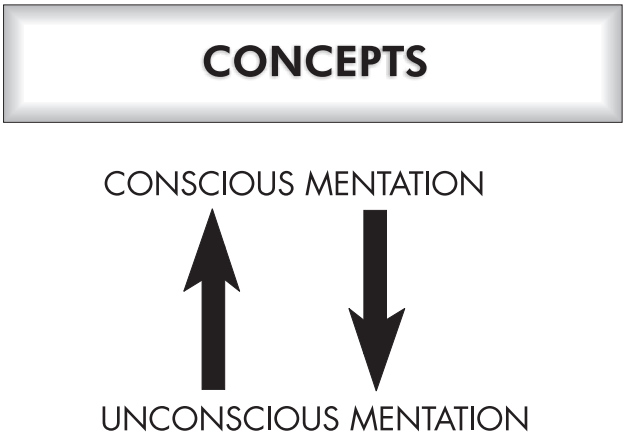
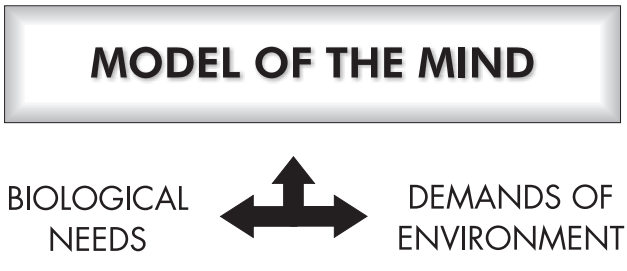


FIGURE 2. Visual aid: model of the mind.



initially agreed to undergo a detoxification. He left the hospital against medical advice 4 days later and continued to drink.

A 35-year-old man was brought to the emergency room after he was found barely arousable at the gasoline station that he had owned for the past 6 months. He and his wife had invested all their savings to purchase the business. He had been working 7 days a week. His anxiety about failure continued and became so intolerable that he was unable to sleep and decided to take some "sleeping medications."

The students easily understand the juxtaposition of the impulsive, self-destructive patient and the overly diligent, depressive patient. The contrast leads to discussion of the problems that they as physicians might encounter in treating the self-destructive patient. This allows introduction of the transference/countertransference paradigm (although these terms are never used) through the observation that it is often easier to care for patients who love us, admire us, and resemble us than it is to deal with patients who are less similar to us and are more demanding of immediate satisfaction.

The students are asked for examples of patients whom they find difficult to tolerate. This arouses anxiety, but the students also rapidly develop some sense of a pattern to the difficulty, and the attendant revelation may arouse a degree of interest in self-exploration. Bringing into conjunction the rather straightforward concepts of psychopathology and personal reactions to it may help the students alter their views of patients as bad or hateful and allow a more clinically useful (empathic) approach.[5] Modification of the physician's sense of being in a struggle with a patient, so that the patient is now seen as an impaired person with limited resources for dealing with the stresses of illness, does bring some immediate reward in the experience of administering clinical care.

Once the stage is set in this way, it becomes possible to begin to explore the spectrum of human psychopathologies and gain a sense of their complicated etiologies. The student can begin to realize that there are developmental/genetic contributions to symptoms as well as biological/genetic predispositions. The goal is to convey to the students that although biological endowment provides the substrate for mental development, environmental influences, mostly in early childhood but also throughout a lifetime, have roles in producing a wide spectrum of behaviors (Figure 4).

MAKING THE CASE FOR PSYCHOSOCIAL HISTORY TAKING

Most students have had some exposure to child development, but they are not always aware to what extent the resiliency of the human mind is tied to experiences in early childhood. A brief discussion about the nature of parent-child relationships can convey the idea that parents are seen as omnipotent, having the power to give and withdraw love, to punish, or to reward. A child soon learns to adapt to parents' expectations and uses the parent as a model. Having stable, predictable, available, and dependable parents in early childhood allows development of the ability to balance restraint against immediate satisfaction, whereas exposure to a chaotic environment during early childhood interferes with the development of a stable and resilient personality.

The concept that life experience matters because it shapes reactions to current life situations can then be

FIGURE 3. Visual aid: concepts.

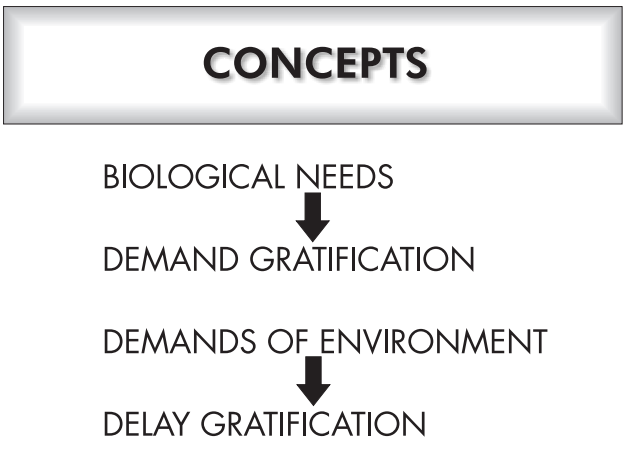
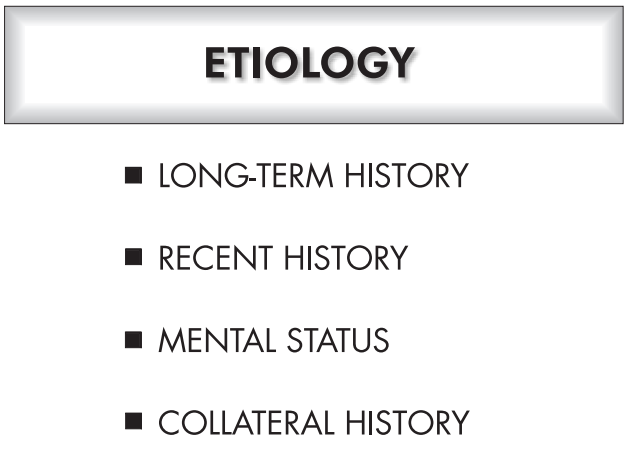


FIGURE 4. Visual aid: etiology.



used to introduce the necessity for longitudinal history taking as an element in diagnosis and the formulation of treatment plans. We return to case illustrations at this point.

A psychiatrist was called to evaluate two 50-year-old men who were agitated and exhibiting evidence of visual hallucinations. Both were intoxicated on admission and have been given the diagnosis of delirium tremens.

I then ask the students, "What else do we need to know?"

Patient A had a history of alcohol abuse for many years and had failed numerous treatment trials. Life history revealed that his mother died when he was three. He was raised in foster homes. He never finished high school. He had had many jobs, all for brief periods of time. He had been married twice but had lost contact with his three children. He lives alone (Figure 5).

The wife of Patient B reported that he lost a job he had held for many years when the company that employed him went out of business. He became despondent because he was unable to find employment. His wife supported the family financially. He started drinking. He was born in a small town where his parents owned a hardware store. He graduated from high school and married his high school sweetheart. They raised three children and had never been in financial difficulty in the past (Figure 6).

Patient A signed out of the hospital against medical advice. Patient B responded to the offer of detoxification and a therapy program. He has been sober for the past 2 years.

FIGURE 5. Visual aid: history.

HISTORY OF PATIENT A

- YOUNGEST OF SIX
- MOTHER DIED WHEN HE WAS THREE
- RAISED IN FOSTER HOMES
- DROPPED OUT OF HIGH SCHOOL
- TWO FAILED MARRIAGES
- THREE CHILDREN
- NO CONTACT WITH FAMILY
- TRANSIENT RELATIONSHIPS
- WORKS SPORADICALLY
- HAS HAD MANY JOBS

As the cases are presented, it becomes clear that although these patients had similar symptoms, their illnesses, treatment, and prognosis were not the same. The student has to learn to understand that the only way one can adequately diagnose, predict, and treat is by including a longitudinal past history in the evaluation.

The concept of ego strength is useful in implementing the historical information obtained. There is no definitive test to measure ego strength; however, a very brief structured history provides valuable information for making such an estimate. It is called an "emergency room five-minute five-point ego function evaluation." The five points are 1) relationship with family of origin, 2) graduation from high school, 3) length of friendships, 4) stability of employment, and 5) present relationships. It needs to be repeatedly clarified, in addition, that there is a wide spectrum of variables and that understanding is essential in patient care management.

FIGURE 6. Visual aid: history.

HISTORY OF PATIENT B

- HISTORY OF ALCOHOL USE FOR ONE YEAR
- NO PRIOR HOSPITALIZATIONS
- NO HISTORY OF PSYCHIATRIC CARE
- OLDEST OF THREE
- MOTHER A PART-TIME SCHOOL TEACHER
- FATHER OWNED A HARDWARE STORE
- FINISHED HIGH SCHOOL

ILLUSTRATING APPLICATIONS TO DIAGNOSIS AND TREATMENT

Emphasis in the pedagogic method can now be shifted to the provision of quality medical care, using the now demonstrated value of obtaining a longitudinal history. The point made is that quality clinical care requires a broad approach to diagnosis and treatment. Careful recognition of symptoms, which was the basis for the development of the DSM system, is important as an initial, reliable diagnostic approach. However, diagnosis cannot be based solely on symptoms in any medical condition, including mental illness. It is helpful to demonstrate this by a very specific analogy to a medical condition; for example, a low hematocrit indicates a symptom called anemia, but one does not usually give a transfusion without trying to determine what might be the cause of the blood loss.

Presentation of the following three case examples further highlights the problems entailed in making a diagnosis on the basis of a symptom checklist.

A psychiatrist was called to see (at different times) three different men who had required an amputation shortly after admission to the hospital 2 weeks earlier. All three presented with symptoms of anorexia, psychomotor retardation, insomnia, hopelessness, and preoccupation with thoughts about death. Thus, all three meet the DSM-IV criteria for major depressive disorder (Figure 7). Unfortunately, when asked about treatment at this juncture, most students come up with a series of psychopharmacologic agents. Additional data reveal that two of the men have had a trial of antidepressants without any symptom relief. The different histories obtained provide a more accurate diagnostic picture and possible alternative treatment strategies:

Patient C was in a vehicular accident, was injured, lost his leg, and his wife was killed (Figure 8). Patient D carries a diagnosis of sarcoma that required the amputation (Figure 9). Patient E is a diabetic who has had numerous depressive episodes in the past and does not comply with the treatment of his diabetes (Figure 10). Patient C, the accident victim, is a mechanic who coached Little League on weekends; Patient D is a physician who is aware that the poorly differentiated tumor is unlikely to respond to treatment.

The use of case material from hospitalized, medically ill patients is of special interest to medical students, most of whom will not have careers in psychiatry. Understanding that grief reactions may occur not only as result of a loss of a loved one, but also as a response to other losses, is crucial. Medically ill patients suffer loss of health, loss of ability to function, loss of body parts, loss of sexual enjoyment. All of that may lead to the development of symptoms of depression. Treatment with antidepressant drugs without psychotherapy may be ineffective in such cases.

The purpose of the educational process described in this presentation is to convey the idea that responses to treatment and management of illness in adults are closely correlated with preexisting ego strength. Throughout the life cycle, ego adaptation capacity and personality affect the reactions to illness. Illness affects the nature of emo-

FIGURE 7. Visual aid: differential diagnosis. S/P=status post.

DIFFERENTIAL DIAGNOSIS

- 54-YEAR-OLD MAN S/P AMPUTATION
  ANOREXIA, INSOMNIA, HOPELESSNESS
- 54-YEAR-OLD MAN S/P AMPUTATION
  FATIGUE, ANOREXIA, HOPELESSNESS
- 54-YEAR-OLD MAN S/P AMPUTATION
  FATIGUE, ANOREXIA, HOPELESSNESS, WORTHLESSNESS

FIGURE 8. Visual aid: history.

HISTORY OF PATIENT C

- VEHICULAR ACCIDENT 1 MONTH AGO
- WIFE KILLED
- PATIENT LOST LEG
- DIAGNOSIS:
  - POSTTRAUMATIC STRESS DISORDER
  - GRIEF REACTION

FIGURE 9. Visual aid: history.

FIGURE 10. Visual aid: history.

tional and mental responses. Diabetes is an example of a disease that may arise at any time from childhood to senescence, leading to physical as well as mental alterations of the affected individuals. Childhood onset leads to dependence on parents and health care providers that may prevent normal maturation and separation from the family. The recurrent episodes of illness and dietary restrictions may lead toward a tendency to somatization and hypochondriasis. Onset in adolescence interferes with normal social activities, causes body image distortions, and may interfere with normal sexual development. In adulthood, dietary restrictions and medical treatments require constant vigilance. At all times, anticipation of development of life-threatening conditions produces anxiety. The individual variation in defense mechanisms results in a wide spectrum of reaction to this as well as any other chronic illness.

SUMMARY

This article describes certain methods of teaching, intended for the instruction of medical students and medical residents. The material is based on psychoanalytic principles. The purpose is to provide a conceptual and, in some degree, affective framework to enable medical students to

1. Learn a simplified model of the mind in order to understand the role of the mind in determining the reaction of patients to their illnesses and to their physicians.
2. Identify a psychiatric disorder.
3. Differentiate normal reactions to medical illness from psychiatric illnesses.
4. Accept the existence of a vast scope of human behavior beyond the known roles of neurotransmitters.

The method is based on a simplified psychoanalytic model of the mind, centered around the concept of ego strength. As such, methodologically it is an example of applied psychoanalysis.

There are other teaching methods to accomplish the goals of psychodynamics teaching. The approach illustrated here is only one, but it illustrates general principles that may be useful in designing from our method.

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