If Freud had not been a doctor . . .

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If psychoanalytic psychotherapy is to be part of the undergraduate medical curriculum, it must be well taught, and demonstrably relevant to the training of doctors. Psychotherapy teachers have a responsibility to devise a syllabus which is clear and relevant and to provide teaching which stimulates and engages the students so that they learn by thinking and understanding. An outline of a syllabus for medical students is included and one seminar as an illustration of interactive learning is described.

If Freud had not been a doctor, would anyone think that psychotherapy was a relevant subject to teach medical students? Philosophy students and psychology students learn about Freud's ideas too, although they tend to learn what Freud *said* rather than what to do with it in their work. Medicine is a vocational degree, however, and an intensely practical course of study in contrast with most undergraduate courses. Medicine is not an 'ideas' degree but a problem-solving one. Medical students are overworked (General Medical Council, 1993) and stressed (Firth-Cozens, 1987) and are inclined to be impatient and dismissive of teaching which does not immediately demonstrate its relevance to their work as medical students and doctors.

Medical students' learning is motivated first by exams and second by interest (Newble & Jaeger, 1983; Hill *et al*, 1994). Within an exam-driven system of education, the students will learn what they believe will be in the exam, and rarely question its relevance; they will memorise almost anything if they think it will get them through the exam. This is what educationalists call 'surface learning', which is useful for rote learning and essential to pass many of the exams we currently give the medical students. The most efficient way to help them pass an exam is often to give them a well written handout. If, however, we want to make them think about a topic, we need to engage their interest. This is called 'deep learning', where the students understand and reflect on the topic and get to know it in a very different way from the information gathering required to pass an MCQ. The most usual opportunities for deep learning in medical training are in the students' experience of clinical work. Medical students love to see patients. During their pre-clinical years they listen enviously to those fortunate enough to have a tutor who has taken them to a ward, or even into theatre. Despite the heavy load of theory and information they have to learn, an element of the old apprenticeship system remains, and they expect and enjoy the hands-on contact of the ward or out-patient clinic. This is where they see how a wearying seminar on histopathological changes in bone marrow translates into a pale young man too ill to go to work.

Psychotherapy teachers often cannot introduce patients in the flesh into their teaching but it should nevertheless be possible to bring the teaching to life and make the students see its relevance. In teaching psychotherapy we prefer to make the students work from their own experience rather than asking them to imagine what a patient's experience might be. Seminars are an opportunity for engaging the students in active thinking, and the informational bones of the syllabus can go into a handout. They will appreciate that this is what they need for the exam, so the teaching must get a reputation for being interesting or fun or only the most dutiful 20% will turn up.

What psychoanalytic psychotherapy should we teach medical students?

We have put a lot of work in the past year into setting up a syllabus which is relevant to the students and which is also internally coherent. Each topic should cross-link to others so that none is seen as a discrete entity.

By the end of the teaching we want the students to understand the following.

(a) **Personality** derives from inborn potential shaped by experience. Repeated experience leads to conscious and unconscious expectations or

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attitudes towards new relationships and new situations.

(b) In ordinary development children have a need for an **attachment** figure who provides security and protection. The need for protection is present throughout life and is activated when a person is frightened or otherwise stressed. Threat of loss of an attachment figure makes people anxious.

(c) People learn ways of protecting themselves from stress or anxiety from childhood onwards; sometimes these **defensive manoeuvres** are helpful, sometimes not. Fixed expectations, attitudes and defences may be out of date and maladaptive, but unconsciously still feel like the only way to cope.

(d) **Psychoanalytic psychotherapy is a treatment** in which it is possible to 'play out' these expectations, attitudes and defences in a setting where the patient can examine and understand them, so that he has more control and more choice in his life. The patient has to be able to tolerate some anxiety in therapy, so it is not a suitable approach for all patients.

(e) Psychoanalytic psychotherapy is only one form of psychological therapy; other therapies, **behavioural, cognitive or counselling** are a better treatment for some patients and some conditions.

How do we teach them?

After the first teaching session we give the students a handout. The first page lists the learning objectives for the psychotherapy teaching and the following pages give all the information necessary to do well in the exam. The work we cover in the seminars is summarised in the handout. We have avoided introducing new terms unless there is no colloquial alternative. The handout and its early introduction is intended to reduce student and teacher anxiety about getting through what is needed for the exam, and leaves seminar time for the students to grapple with ideas and problems.

A good teacher will draw up a lesson plan. Anyone who has ever organised a children's party will remember how important it is to make sure that every moment is accounted for, and that a series of stimulating and supervised activities will leave no space for a child to become bored or disruptive. The lesson plan is rather similar: it is a list of what the teacher wants the students to learn in the session and how she is going to teach it. Drawing it up takes time, and cannot be cobbled together in the car on the way to work on the morning of the seminar.

Nothing can be more tedious for the learner nor dispiriting for the teacher than the expert talking for two hours to a passive group of half awake students, the liveliest of whom are conscientiously scribbling down every word. Good teaching is interactive and task-based, and the teacher must know what the structure of the session is to be; good teaching does not usually happen spontaneously and at any stage in the session the teacher will know where the content has got to and where it is going next. If it can be related to the students' existing experience it will immediately become easier to understand and remember. In medical teaching the practical application should be demonstrated.

Illustration

We have six hours' teaching of the medical students: what follows is the outline, derived from the lesson plan, of the first two-hour session. The seminar is for about 40 students. It is part of the teaching programme for students doing their 11 week psychiatric attachment and this seminar is titled, 'Introduction to Psychotherapy'. Throughout the session didactic teaching alternates with a task or activity, each episode lasting between 10 and 20 minutes.

Introduction. We begin by telling the students that they will get a handout which covers what they need for the exam and that they need not make notes.

Didactic. In the first 15 minutes we use traditional didactic teaching, although involving the class with questions, and give a definition of psychotherapy, going on to describe the different kinds of mainstream therapy; psychoanalytic, behavioural, cognitive and counselling or supportive therapy. We tell them briefly which patients benefit from which approach, and we say that we will be teaching them mainly about psychoanalytic psychotherapy.

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Questions. We explain that the overall aim of psychoanalytic psychotherapy is to modify personality, and ask the class to define personality and to suggest the kind of words they use when they describe a person's personality.

Activity (task). The students now move on to an activity which should stimulate them to think from their own experience but is not intrusively personal. Working in groups of four, they are told to find four adjectives to describe the personalities of a good and bad teacher they have known in their three years as students. They must describe to their group, (although not to the class or the teacher), specific incidents to illustrate each adjective. This is a popular exercise. After ten minutes we gather as a class and create a composite description of the effective and ineffective teacher.

Discussion. This is followed by a brief episode of teacher-led discussion about which aspects of a person's life or functioning a psychiatrist or GP would examine to assess a patient's personality. Performance at work is one of these and we now go back to our 'clinical' example of the well functioning and less well functioning teacher. We have an understandable structure on which to hang the notion of a spectrum of personality functioning, from the most healthy, to less than optimal to personality disordered. Why do we develop our individual personality characteristics? The students agree that personality is partly innate or genetic and partly derives from early experience.

Didactic. After a coffee break, the teacher outlines the importance of attachment in human life and early development. Attachment behaviour is one aspect of personality development which has been systematically studied and evaluated, and there is research-based evidence for the relationship between maternal sensitivity to infant cues and secure and insecure infant behaviour. We here begin to make the link between the child's anxiety and the ways it learns to protect or defend itself. Early coping mechanisms can be observed, and we can make predictions with some reliability about specific interpersonal vulnerabilities which insecure children are likely to show in later childhood.

Activity (task). The next activity is observational. Using work sheets and working in groups, the students study infant behaviour on a video recording and score behaviour and affect which they observe in the children. They classify the behaviour of each child and can see that each child has learned a different way of dealing with stress, each being appropriate to the child's present relationship.

Didactic. Finally the teacher explains that these infantile patterns of defence tend to persist, and that they become part of the total behaviours and attitudes that we call personality.

What have the students learnt?

In this seminar they have learned about healthy and unhealthy personality functioning, and that personality is a dynamic concept, and one which we assess in terms of a person's attitudes and behaviour. They have seen that children learn very early how to protect themselves from anxiety, and understand that some 'protective' mechanisms may become part of the personality. Because 'personality' is a familiar and colloquial word the students are comfortable in relating it to their own lives and are highly engaged in an exercise which classifies familiar experience. A series of achievable tasks maintains their interest and allows them to use their ability to think and observe in the process of learning.

In the first session we do not explicitly relate the teaching to medical practice other than in the importance of personality functioning in psychiatry. We have laid the foundations for exploring the place of anxiety in everyday life, and more specifically, in medical practice. In subsequent seminars we will discuss what makes patients anxious, how they might cope with anxiety and how this might affect their approach to staff or to treatment. We use clinical examples and video material as much as possible. The students think about how medical training prepares them to deal with stress, and try to decide which protective mechanisms in the patient and in the doctor are important and helpful to good practice and which less so.

Are attachment and dependency to stay with us throughout life or should healthy adults have grown out of it? What circumstances will make a patient more dependent on the doctor and how should the doctor respond? Is dependency a sign of weak personality?

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If they understand that we all approach new relationships with expectations derived from earlier experience the students can work out how psychotherapy might be effective in elucidating a patient's unrealistic expectations so that the patient can change them. Will that be possible for all patients or are there some people for whom this would be an unhelpful approach? Why? What would be better?

As described above, we use active teaching as much as possible, getting the students to draw on their own experience and introducing case material wherever possible.

Conclusion

Freud was one of the most influential thinkers of this century and his ideas have become part of our cultural assumptions. It is common to hear friends mention unconscious motive casually in social conversation. The students take for granted the notion of unconscious mind and unconscious motivation and they see it as self evident that adult personality is affected by previous experience.

Despite this, there is a good deal of ignorance among doctors about psychotherapy as a treatment, about which patients to refer and what the patient should expect. The 'service users' want more 'talking treatments', hence the burgeoning of counselling services, some of them of dubious quality, and many doctors seem to feel that while counselling or sympathetic listening is helpful or at least harmless, psychoanalytic psychotherapy is a suspect entity, and something to do with wanting to sleep with your mother.

Doctors should know what psychoanalytic psychotherapy is, and know which patients may be helped by it and which not. We as teachers should demonstrate that there is a coherent theory which underpins clinical practice, and that this theory illuminates and helps us understand the processes of psychological development. It is our responsibility to ensure that our students discover the relevance of psychodynamic understanding to medical practice, not only from memorising symptoms and definitions, but from their own curiosity and excitement in exploring and understanding something of the human mind and personality.

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Reading List for Trainees: General Psychiatry. Second revision, 1995

The Library has prepared a new edition of this reading list which aims to assist trainees in their preparation for the examinations. Copies are available from the Publications Department, price £2.50.