

# Addressing medical students with psychodynamic education

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## Abstract

Mental symptoms rank high among medical students and residents. Roughly one fourth of the student body is affected. This widespread presence may influence the core of our profession: Emotions. Medical students who tend to suppress their negative emotions display a higher prevalence of depressive symptoms, anxiety and distress. The patients' symptom onset is often linked to a specific time of personal significance. Patients regularly offer a relationship by pointing towards psychosocial issues. The students' suppression of negative emotions may lead to a neglect of topics connected to these emotions during history taking. This leads to an abandonment of the biopsychosocial model of health and inhibits the growth of a doctor-patient relationship. We need preventive measures to decrease the high prevalence of mental symptoms and improve our patient's health. Mandatory classes on patients' psychosocial clues and students' emotional response could improve two crucial points: The reduction of the students' own symptoms and a curious investigation of the patient's entire history. This personal view by a German MD is a pledge for a paradigm shift in the medical curriculum.

**Keywords:** medical education; medical school; students' health; medical student health; Michael Balint; emotions; psychodynamic education

## Addressing medical students with psychodynamic education

During my pre-clinical years as a medical student I was astonished by the vast number of troublesome student-student as well as student-patient relationships based on the high prevalence of distress. This distress in turn is caused by and contributing to the students' mental symptoms. Difficult, a vague adjective, is commonly used to describe these students. The term is challenging, open to interpretation and recently discussed (de Leon *et al.*, 2018). It should be avoided because it hides the severity of this issue.

Depressive symptoms, anxiety and distress rank high among the student groups (Guthrie *et al.*, 1995; Moffrat *et al.* 2004; Aktekin *et al.*, 2001; Givens and Tjia, 2002; Clark and Zeldow, 1988; Rosal *et al.*, 1997; Mosley *et al.*, 1994,

Rueckert and Ancane, 2018; Rueckert, 2016; Roberts *et al.*, 2001; Dahlin, Joneborg and Runeson, 2005; Puthran *et al.*, 2016; Bugaj *et al.*, 2016; Bugaj and Nikendei, 2018). Depressive symptoms are present in roughly 25% of the student body (Givens and Tjia, 2002; Clark and Zeldow, 1988; Rosal *et al.*, 1997; Mosley *et al.*, 1994, Rueckert and Ancane, 2018; Rueckert, 2016; Puthran *et al.*, 2016; Tam, Lo and Pacheco, 2019), even if the prevalence varies among studies (Hope and Henderson, 2014). Despite a prevalence, we lack a clear picture regarding the etiology. Suffering from depressive symptoms as a medical student is associated with being female, problems adjusting to the university curriculum, personal and family relationship issues, and exposures to death and suffering (Dahlin, Joneborg and Runeson, 2005, Bugaj, 2018; Tam, Lo and Pacheco, 2019).

The symptoms prevail after graduation. A similar number of residents suffers from depressive symptoms and anxiety (Buddeberg-Fischer *et al.*, 2009; Pereira-Lima and Loureiro, 2015). This widespread presence may affect the core of our profession: Emotions.

### **Unexpressed emotions restrict the ability of history taking**

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My first research as a student focused on the mental symptoms of international students and later the emotional adaptations to stressful life events (Rueckert and Ancane, 2018; Rueckert, 2016). Both hold their biases. In my view, the findings of these researches indicate two points:

1. Though the level of mental symptoms varies, their overall prevalence is high.
2. Medical students who tend to suppress their negative emotions (such as shame, anger, sadness or disgust) display a higher prevalence of depressive symptoms, anxiety and distress.

The suppression of negative emotions may lead to the students' neglect of topics related to similar emotions while they are building a doctor-patient relationship. This barrier can hinder a young doctor's willingness and ability to be empathetic to the patient's unique personal life. Once medical students inhibit their own emotional experiences, it is questionable whether a curiosity for the patient will develop. In addition to this problem, the current curriculum may lead to a decrease in curiosity (Bugaj, 2018).

During patient visits students often excel in a focused history taking. They investigate the patients' subjective and objective state, as well as personal medical history. Unfortunately, the often-subtler hints of interpersonal issues (such, as stressful life events or relationship difficulties) connected to the hospitalization are not perceived by medical students. This issue was recently investigated by an audiographic research among general practitioners. Patients regularly point towards psychosocial issues, which remain "unheard" and are not processed by the doctor due to the believed insignificance for the diagnosis (Salmon *et al.*, 2004). The reason for the neglect of subtle hints and the believed insignificance might be buried in the previously discussed topics: the suppressed emotional world of the students with their high prevalence of illness.

### **We should promote the exploration of students' own emotions**

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Interpersonal problems and emotions are crucial in medicine. Psychodynamic theory posits that the symptom onset is often linked to a specific time of personal significance in which an unconscious intrapsychic conflict can no longer be suppressed and tries to find an outlet. I would argue that students seem to not be interested in the correlation between onsets of clinical symptoms and its personal significance to the patients, because it would show a correlation to their own repressed conflicts and the connected emotions.

In order to tackle the issues related to the patient-doctor relationship, and unnecessary treatments due to an improper history taking, we should find ways to address the student's own emotional well-being during their education.

Unfortunately, in medical school settings questions, which aim to find this possible correlation are disregarded by students and teaching doctors alike. Psychodynamic ideas had no place, and still have very little recognition in medical curriculums.

## **Taking action – an experiment**

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In 2016, I founded an extracurricular student group for students to tackle the lack of emotional investigation during patient visits and to give students a space to study psychosomatic and psychodynamic concepts. The group was open to anyone interested. Up to this day, the group focuses on patient-doctor relationships, the investigation of emotions during patients' anamnesis and psychodynamic theories in order to boost curiosity and make up for the lack within the curriculum. The groups were well attended ranging from 10-40 students with the core group still consisting of only six students. The classes included interpretations of patient-doctor role play, movie interpretations, psychodynamic concepts and active discussions on students' current communication issues.

The feedback of students was positive, mainly mentioning the lack of these topics in the general curriculum. Yet, the most interested students often stopped showing up to the group or visited it sporadically. I was wondering about the occasionally low attendance and fluctuation of students. An anonymous in-group survey revealed that the main reason for students missing the meetings was due to the university's workload and scheduling issues. A minority mentioned lectures being too long and uninteresting, while one interviewee mentioned personal emotional problems interfered with the participation.

Could the avoidance of the discussed emotional and mental problems be due to the students own emotional qualities? After all, we were exploring negative emotions in depth and six students attended regularly, without interruption, independent of the student curriculum and personal problems.

## **Learning from seventy years of history**

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While trying to find an answer to this question, I was reminded of Michael Balint. In „The doctor, his patient and the illness“, Michael Balint mentions a similar problem in the early pioneer work. In the 1950's Balint began working with general practitioners and helped them to clarify the understanding of unexpressed emotional qualities in the patient-doctor relationship. In one of the last chapters he discusses the reasons for doctors leaving the group. His finding concerned the doctors' withdrawal due to their own neuroses. He approached the problem by selection interviews (Balint, 1960; Balint *et al.*, 1966) while disregarding possible outside conditions leading to the withdrawal. Today this topic is still relevant for Balint groups. Three reasons are mentioned for the physicians' withdrawal: The physicians own neuroses (nowadays referred to less judgmentally as "dynamics"), problems of hidden agendas or rivalries within the group, and outside conditions defining the group (Kjeldmand and Holmström, 2010).

Our attending students were quite clear about the latter. The students' dynamic seems to point, as mentioned in the introduction, to the suppression of the own negative emotions, which are unavoidably brought up in group setting. Hidden agendas, group rivalries might have been present and are being investigated. Due to a dedicated attendance of the yearly changing core group members, the belief consolidated that the students underlying dynamics was the core issue.

The problem regarding the low attendance slimmed down, once visitors willing to come back were obliged to give a lecture and attend a certain number of classes in order to receive a certificate of participation each year.

Despite their own dynamics students showed up when given recognition for their work. The authoritarian approach, part of any medical school, was successful.

## **Bringing emotions and psychodynamics back to its roots**

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Medical didactics with a focus on psychodynamic education may influence medical students on two crucial points: The reduction of the students' own symptoms and a curious investigation of the patient's entire history. Mandatory classes focusing on psychodynamics could help to overcome issues of mental health in medical schools and the neglect of the psychosocial aspects of the patient.

Balint groups are known to be beneficial to the mental health of physicians and the doctor-patient relationship (Kjeldmand, Holmström and Rosenqvist, 2004; Kjeldmand and Holmström, 2008; Turner and Malm, 2004; Margalit *et al.*, 2005). Balint himself ran a group for students from 1962 to 1969 (Balint, 1969). Integrated Balint groups could prevent the aforementioned issues by building an empathetic professional identity, discussing negative role models and (negative) feelings related to patients (Torppa *et al.*, 2008; Monk, Hind and Crimlisk, 2017). Research suggests modifying Balint in order to fit the specific student clientele (Torppa *et al.*, 2008, O'Neill, Foster and Gilbert-Obrart, 2016).

We need to find a way to introduce medical students to Balint groups. There, students could focus on the personal issues of patients, explore the connected negative emotions and thus learn to talk about their own negative emotions. Subsequently, benefiting the students as well as patients. Two questions will remain for the future 1. How to best lead Balint student groups? 2. Can future studies substantiate these statements?

## **Take Home Messages**

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- The importance of emotions in medical education and training should no longer be ignored.
- We, as medical educators and physicians, should promote the exploration of students' own emotions to promote their and patients' well being.
- To do this, we need to develop psychodynamic strategies and explore their possibilities and limitations in practice.

## **Notes On Contributors**

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Kamiar Rueckert is a German medical doctor currently working at the Heidelberg University Hospital.

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## Appendices

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None.

## Declarations

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*The author has declared that there are no conflicts of interest.*

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