Personal Paper

Psychotherapy: experience as a medical student

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"Hello, Mr Wilkinson." As a third-year medical student I greeted my patient for the first time. "My name is Mr Garner. Please take a seat. As your therapist, I will see you each week for an hour." This was the beginning of an 18-month experience in psychotherapy, a unique and carefully supervised scheme run by the department of psychiatry at University College Hospital, London. Outlined in this article is how the scheme is organised; my own experiences in it; the immediate gains as a student; and, finally, the way it has altered me as a junior doctor in the past 15 months.

My patient had been referred after sustaining superficial lacerations when he deliberately broke his father's magnifying glass over his own head. The casualty officer (UCH trained) realised that this patient needed more than a bandage, and after assessment by a psychiatrist in UCH's outpatient department he was offered free psychotherapy by a student therapist. All patients are carefully chosen; none are suicidal or psychotic, and all may benefit from therapy. Junior clinical students may take part in the scheme. Many volunteer but have dropped out by the time a place on the group becomes available. The time commitment of at least three hours a week puts many off, but nevertheless all the groups are full, as 15-20% of each year take part. Supervision is weekly, in a group of three to five students with a consultant psychiatrist or psychotherapist.

Initial session

Everything, even psychotherapy, has a beginning, a middle, and an end. Initially, the student joins the group and spends several sessions listening to the supervision of others already in therapy. After being allocated a patient, the referral letter and psychiatric assessment are discussed in the group. People talk about their first session: the most frightening event ever! Every detail that can be anticipated is talked over: the introduction, whether to shake hands, the position of the chairs. Some students state that they would automatically sit at the desk. Why might they be doing this? What kind of relationship do they wish to establish?

Soon the student feels confident enough to meet his patient and enter into the contract, a verbal agreement of commitment. An hour a week at a mutually convenient time is quickly fixed. Sometimes the patient asks questions about what will happen, and it begins: what is the patient looking for? The initial sessions are full as the patient talks; he is as anxious as the student, and will also have prepared himself for the sessions.

In the weekly supervision session each student goes through his notes written just after he has seen the patient. He is encouraged to write down all that he remembers, word for word

when it seems important. Each fragment is discussed and is related to the session as a whole, to previous sessions, to the patient's problems, and to his relationship to the therapist. Bits not written down are sometimes spontaneously recalled in discussion; sometimes it is significant that they were not recorded. The dynamics gradually emerge; and with careful steering and support, the student goes back refreshed with ideas to use when appropriate. As the world of psychotherapy unfolds before his eyes, his skills become sharp and the sessions progress from being supportive to becoming more analytical. The student learns to tolerate silences; their presence is important, as what is said to break them. He learns to recognise transference and when to use it. Counter-transference occurs and its meaning is discussed openly in the group.

Many patients stay in therapy for 12-18 months continuously with the same therapist. A few patients fail to turn up after the initial sessions; they are encouraged to reattend by letter, but if they do not return the student is offered another patient. As the student approaches finals or elective the impending end is brought up well in advance. The patient's reaction to this inevitably appears and is made use of. Finally, after careful group discussion, suitable alternatives may be offered if required. Some go on to group therapy; others are offered a more intensive programme at one of the London psychotherapy schools, and some become patients of more experienced therapists at UCH. No patient has ever been made worse by therapy. Many benefit and need no further therapy after the student leaves.

Short-term gains

My own patient presented as previously outlined, having broken his father's magnifying glass over his own head. He was 28, worked in a bank, and was depressed and frustrated by his failure to make friends, women in particular. He blamed his authoritarian upbringing, in particular his father, a strict Methodist, for not allowing him to develop as a man. He described himself as mean with money; it became evident he was careful with his emotions too. Initially, silence at the beginning of a session was common, and it was as if I had to give him permission to speak. This was denied, then followed talk of his father. I might have been right, but he was not yet ready to hear it. The week after a particularly dynamic session he was late. After profuse excuses, he talked about the office, stating how he disliked one-to-one conversations and how he wanted other people around, so that he could merge with the background. I suggested that he perhaps felt uncomfortable here, and that might be a reason for being late. We were beginning to move forward. . . .

One of his main anxieties was that he would be a disappointment to others, and be rejected. His fear of failure was so acute that he did nothing unless guaranteed of a safe outcome. The very least I did was to be a person prepared to work with him weekly, whatever he said. As the months progressed he became

happier but changed little, although he gained insight into himself. For once there was someone outside his family. He moved house away from his parents and left therapy a more confident person. Limited change, but at least some.

Naturally, we had difficult patches. For weeks he said the same things about his depression, how he thought it was caused. I was tearing my hair in the supervision group. It became evident that this was his way of staying on safe ground, avoiding deeper conflicts. Even pointing this out to him, I felt we were still not moving. I missed two supervision sessions. The psychiatrist immediately became concerned and I returned. I stated that little new had happened, so little that I had not recorded anything—but I recalled as best I could. It was a startling revelation. A lot had happened. He had mentioned his mother for the first time in therapy, and talked about her depression. My own mother had suffered with depression, and hence my "session repression." The group turned into a supportive network where I could work through my feelings, helpful to me, and helpful in removing the therapeutic block.

As can be seen, one of the gains of the scheme was being part of a group. Although short-term gains are dwarfed by the long-term benefits, the former are important in motivating the student, especially when the scheme demanded a weekly time commitment of about four hours on top of the clinical timetable. It was the first time any of us had responsibility to our own patient. It was new to be in such close contact with consultants. The intellectual stimulation made it a highlight of the clinical course.

Long-term benefits

The long-term benefits are Protean. Naturally, it provided experience for the potential psychiatrist; more important was the education for the future hospital doctor or general practitioner. To begin with it provides an awareness of psychosomatic complaints, often ignored or more usually missed in hospital practice. Secondly, for those patients with physical illness therapy improves the student's capability to care for them: he is able to listen, and can pick up the patients' feelings and use them to allay anxiety; he is sensitive to the subconscious in the patient and in himself; and finally, he realises that the patient as a whole is his responsibility.

To colour in the resounding importance of psychotherapy in training "tuned in" doctors I will give a few examples from my own experience. Missed psychosomatic complaints abound in surgical outpatient departments: a young man with intractable left testicular pain with no demonstrable pathology caused an irritated registrar at a peripheral London hospital to cure the complaint by orchidectomy. The man returned a few months later with pain in his other testicle: a treatment dilemma, such that the patient was presented at a case conference. "Do we remove his other testicle?" The team asked the audience and were taken aback when a UCH medical student suggested that the patient saw a psychiatrist, as the pattern was typical of someone with a psychosomatic illness.

Taking patients with physical illness, how often do doctors listen to them? Do doctors acknowledge their feelings and help them work through their anxieties? As a surgical house surgeon I saw an elderly man told that he had a tumour in his oesophagus. His whole appearance was of a man burdened to breaking point with worry: hardly surprising, it might be said. Next day I had a chat and I asked him what was worrying him most. "Will I choke to death?" he blurted out. Gently, he was reassured that this would not be allowed to happen. His demeanour changed, and he left hospital looking forward to being with his wife. Psychotherapy trains where to anticipate anxieties; for instance, a woman suffering a spontaneous abortion will doubt her ability ever to have a normal child. With this awareness, the doctor is able to bring the subject up, allow her to talk about her worries, then carefully reassure her if necessary.

Sometimes patients give subconscious clues to their anxieties. A training in psychotherapy means these clues can be usefully picked up. A man was due to go home after a heart attack. His wife anxiously asked when he could start gardening again. As I had the feeling she was thinking more about sex than the garden, I talked about resumption of all physical activity including intercourse after a convalescence, so long as it was not a marathon night together or a three-acre garden. They both looked relieved, and stated that they had been too frightened to ask about sex.

One's own subconscious is a whirl of feelings of such complexity one can only dream about it, but there are times when questioning one's own subconscious can help you and the patient. Take, for example, the 3 am casualty aspirin overdose call. Trudging down the palatial corridors of Ninewells Hospital, I looked for a stone to kick. "Bloody overdoses"; a phrase muttered by many housemen. It was a long corridor: why, I wondered, do I feel like this about a patient not yet seen? It was apparent that it was not the patient; it was because I had to get out of bed at 3 in the morning, and this was a person, like any other, deserving proper medical care, and perhaps an offer of psychiatric help. Being aware of my own feeling helped me make a fairer assessment of the patient.

Finally, psychotherapy teaches you that the whole patient is your responsibility. The history and examination are conducted with empathy. Whether it is an overdose or an "inability to cope at home" it is the junior doctor's job to take proper care that the patient is looked after and channelled in the right direction. Doctors often state that they do not have enough time to do this. This is a poor excuse for disclaiming their responsibility. Why? Firstly, there is always time. Secondly, the actual physical quantity of time required is small. Rather it is an attitude of mind, an approach to patients as individuals, whose needs and anxieties are evident from thousands of clues in their appearance, the way they walk, what they say, and how they act. Psychotherapy teaches you to treat patients as people. When will medicine as a whole learn to teach some of these skills to the thousands of medical students who have not had the opportunity of an experience in psychotherapy?

Is it possible to predetermine the sex of the fetus, and are any studies being done of techniques to enable parents to choose the sex of their offspring?

There is no reliable method of preselecting the sex of the fetus,¹ but there is an extensive folklore on the subject.² Recommendations about the timing and technique of intercourse have been made, based on the theory that the male (Y-bearing) sperm is smaller and faster moving than the female (X-bearing) sperm, and will therefore reach the ovum first if conditions for ascent through female genital tract are optimal. Many of the recommendations for increasing the chance of a son have been questioned, however. Alkaline douches (two tablespoons of baking soda to a quart of water) have been recommended, but recent work has shown sperm motility to be unaffected by pH.² Intercourse at the time of ovulation has been recommended, but a recent study³ suggested that intercourse delayed until two or more days after ovulation is more likely to produce a boy—the chance of this being 65%. Deep penetration (if possible from the rear position) and simultaneous orgasm have been recommended for producing boys: so far nobody has questioned these. Current studies are concentrating less on coital factors and more on the separation of X-bearing and Y-bearing sperm before artificial insemination, in both animals and women. Differential centrifugation, density gradient separation, and microelectrophoresis have been looked at, and recently favourable results have been claimed from the use of albumin gradients.¹ The problem is that the total sperm count is reduced as the proportions of X-bearing and Y-bearing sperm are altered. The only sure method of choosing the baby's sex is selective abortion, and this method is used only in cases of severe sex-linked disease.

¹ Anonymous. Choosing the baby's sex. *BMJ* 1980;280:272-3.

² Glass RH. Sex preselection. *Obstet Gynecol* 1977;49:122-6.

³ Harlap S. Gender of infants conceived on different days of the menstrual cycle. *N Engl J Med* 1979;300:1445-8.