Psychodynamic Psychiatry, the Biopsychosocial Model, and the Difficult Patient

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KEYWORDS

- Difficult patient • Biopsychosocial model • Enactment
- Treatment-resistant disorders • Psychodynamic psychiatry

KEY POINTS

- Psychodynamic psychiatry is the intersection between general psychiatry and psychoanalysis as a theory of mind, and is built on a biopsychosocial model for understanding and treating mental disorders.
- The biomedical model has not lived up to its promise and is not supported by emerging science as robustly as is the biopsychosocial model.
- The "difficult patient" emerges in part from the limits of our treatment models and treatment methods.

INTRODUCTION

Psychiatry is the medical specialty that focuses on disorders of the mind, especially disturbances in thinking, behavior, and emotions. Psychoanalysis refers here not to a form of individual psychotherapy, but rather to a theory of mind that attends to an individual's unique developmental trajectory within a familial and cultural context, with attention to the important impact of unconscious factors on human thought and behavior. Given these 2 definitions, we can think of psychodynamic psychiatry as the area of intersection between the domain of psychoanalysis as a theory of mind and the domain of general psychiatry. Psychodynamic psychiatry offers a perspective that allows us to engage, understand, and be useful to difficult-to-treat patients.[1]

All of us have experienced work with patients we come to view as difficult to treat or, as they are sometimes called, "treatment resistant."[2] There are patient-specific and disorder-specific characteristics that make patients difficult to treat, but that which is difficult often resides not in them, but in us, and in the limitations of our treatments.

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Abbreviations	
BPD	Borderline personality disorder
CBT	Cognitive behavioral therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
PDT	Psychodynamic therapy
RCT	Randomized controlled trials
RDoC	Research domain criteria
STAR*D	Sequenced Treatment Alternatives to Relieve Depression

This article is in 2 sections that each address different kinds of limitations that contribute to the experience of patients as difficult. The first section addresses limits inherent in the biomedical model that threatens to supplant the biopsychosocial model, which is better supported by research and more salient for understanding and treating mental disorders. The second section elaborates the way our inevitable human vulnerability to countertransference enactments contributes to the experience of patients as difficult.

LIMITATIONS OF THE BIOMEDICAL MODEL

Mathematician George Box noted that, "All models are wrong, but some are useful."[3] It was George Engel[4] who proposed the biopsychosocial model, a model suggesting that understanding and treating people with mental disorders requires attention to the contributions of their biology, individual psychology, and social context. The biopsychosocial model is entirely congruent with psychodynamic psychiatry. However, over the last several decades, a narrower biomedical model has been in ascendancy and the biopsychosocial model has been in decline. Popular psychiatrist authors like Nasir Ghaemi, for example, have criticized the biopsychosocial model as lacking rigor.[5]

There was hope in the 1990s that the eventual decoding of the human genome and findings from brain research would confirm the value of a biomedical model. Current director of the National Institutes of Health, Francis Collins, who was then director of the National Human Genome Research Institute, suggested in 1999 that a genetic revolution throughout medicine would emerge from the Human Genome Project. At that time, Collins[6] described 6 major outcomes expected to follow from decoding the human genome:

1. Common diseases will be explained largely by a few DNA variants with strong associations to disease;
2. This knowledge will lead to improved diagnosis;
3. Such knowledge will also drive preventive medicine;
4. Pharmacogenomics will improve therapeutic decision making;
5. Gene therapy will treat multiple diseases; and
6. A substantial increase in novel targets for drug development and therapy will ensue.

Although there are some small advances toward achieving these outcomes in the rest of medicine, in psychiatry the promise has fallen short. Associated with these hopes for the future are 3 implicit assumptions related to the biomedical model:

1. Genes equal disease,
2. Patients present with single disorders that respond to specific evidence based treatments, and
3. The best treatments are pills.

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