The Overall Diagnosis

Psychodynamic Psychiatry, 6-Minute Psychotherapy, and Patient-Centered Care

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KEYWORDS

- Psychodynamic psychopharmacology • Patient-centered medicine • Alliance
- Psychotherapy

KEY POINTS

- Patient-centered medicine derives from the work of Michael and Enid Balint, and provides a path by which psychiatry can reengage psychodynamic concepts to improve patient care.
- Key concepts in patient-centered medicine include the biopsychosocial perspective, the patient-as-person, the doctor-as-person, shared responsibility and authority, and the therapeutic alliance.
- Corresponding principles in psychodynamic psychiatry support the development of the treatment relationship and improved outcomes in psychiatric treatment.
- The prescribing psychiatrist can use a modified form of psychodynamic psychotherapy to enhance patient care.

We physicians cannot discard psychotherapy, if only because another person intimately concerned in the process of recovery —the patient—has no intention of discarding it... A factor dependent on the psychical disposition of the patient contributes, without any intention on our part, to the effect of every therapeutic process initiated by a physician; most frequently it is favorable to recovery, but often it acts as an inhibition.… All physicians, therefore, yourselves included, are continually practicing psychotherapy, even when you have no intention of doing so and are not aware of it.

—Freud, S. (1905). On Psychotherapy, p. 258–259

INTRODUCTION

The explosion of knowledge owing to biological research in psychiatry has been accompanied by decreased emphasis on psychological understanding of patients,

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their illnesses, and the treatment relationship. Meanwhile, the development of patient-centered medicine[1] has led to an increased appreciation in primary care of nonbiologic dimensions of care. Patient-centered medicine, developed from the work of the psychoanalytic theorist Michael Balint, has its roots in psychodynamic concepts. These concepts can assist the prescribing psychiatrist in better understanding the patient's needs, improving the therapeutic alliance, and integrating modified psychotherapy.

PSYCHIATRY IN THE AGE OF NEUROSCIENCE

The excitement accompanying the great research discoveries in biological psychiatry during the last century[2] was accompanied by pressure on physicians to focus on biological interventions. Pharmacotherapy in general is better compensated than psychotherapy, and American publishing has shifted from favoring the psychological to focusing on psychopharmacologic research.[3] Meanwhile, as psychiatry has become increasingly focused on the medical model, general medicine experienced an upsurge of interest in patient-centered care, bringing a focus to the "patient-as-person" and "doctor-as-person" to the practice of medicine.[4] Tellingly, in 1 metaanalysis,[5] out of 26 studies examining the effects of psychosocial interventions to improve antidepressant adherence, 25 came from the primary care literature and only 1 from organized psychiatry.

In 2010, then director of the National Institutes of Mental Health Thomas Insell[6] wrote in explaining the purpose of the Research Domain Criteria (RDoC) project that guides National Institutes of Mental Health funding, that the RDoC assumes that mental illnesses are best conceptualized as brain disorders, that the corresponding dysfunction of brain circuits could be identified using tools of clinical neuroscience, and that data from neuroscience would yield "biosignatures" that would lead to improved clinical management. In 2017, in an interview for *Wired* magazine,[7] Insell admitted that 13 years of neuroscientific research had not "moved the needle" in addressing suicide, hospitalizations, or psychiatric recovery.

Our field has invested much of its creativity and resources in biomedical research. Meanwhile, rates of death by suicide have increased significantly since 2000,[8] outcomes of treatment for serious mental illness are not notably improved, and treatment resistance has become increasingly prominent in the psychiatric literature.[9] One likely reason that neuroscientific advances seem not to have transformed the experience of real-world patients is that psychiatry has neglected some of its most potent tools. In allowing itself to be increasingly restricted to biomedical targets, the field neglected the profound influence of psychosocial interventions on treatment outcomes.

PSYCHODYNAMICS AND THE ORIGINS OF PATIENT-CENTERED CARE

In 1930, the physician, psychoanalyst, and progenitor of patient-centered medicine, Michael Balint, noted the growth of pharmacologic advertising and laboratory tests. He observed concordant changes in practice. Older physicians, he noted, were skilled in sensitive clinical observation,[10] whereas younger physicians seemed to know their patients less well. Although Balint wrote nearly 90 years ago, his observations seem applicable to our own experience. Balint's work became the basis for the movement known as patient-centered medicine, a term he coined in his work with his collaborator and spouse, Enid Balint.[11,12] The Balints advocated for the concept of the "overall diagnosis."[13] "This should include everything that the doctor know and understands about his patient; the patient, in fact, has to be understood as a unique human being."[12]