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Foreign report

Psychiatry in the USA

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In a rash moment of bonhomie, having offered to one of the editors to write a personal view of psychiatry in the USA today, and with his encouragement to proceed, I find myself a long time later reflecting as to why the task seems to have been so daunting. Interpretations regarding my DSM-III-Axis II disorder apart, the numbers involved perhaps provide some of the reasons. There are 38,276 psychiatrists in this country, mostly paying dues ($300.00 per year) to the American Psychiatric Association, which has 76 district branches across the country, with between a few dozen and a few thousand members each; $428 billion spent on total personal health care in 1988, approximately two-thirds of which was covered by Federal Government programmes, of which $351 million went to the mental health sector; 150,000 patients treated for longer than one year in the long-term care psychiatric hospitals in this post-deinstitutionalisation era; and 6.5 million persons resident in nursing homes (at an estimated cost of $46 billion) of whom more than 50% are estimated to suffer from Alzheimer's disease. From such an array it is difficult to distill the essentials with much confidence as to their reliability or significance. What follows is therefore selective and impressionistic.

Looked at from a broad viewpoint, American psychiatry towards the end of this decade appears to be regarding the 'dissent', 'controversy' and 'identity crisis' that have characterised the profession as now crystallised out along two axes. The first or 'theoretical' axis runs between the biologic or 'remedicalisation' pole and the psychoanalytical one. The biologic pole takes one of its bearings from DSM-III and its offspring (described by some as the 'Chinese menu' approach to diagnosis) and is associated with other 'structured' approaches, e.g. interviews for use in both research and clinical practice and even manuals for therapies. I have to confess that recently I find myself more in accord with this approach than I was following my arrival from the UK. The sight of our young resident (registrar) checking off items on a Hamilton Depression Rating Scale, barely bothering to lift her (almost half of psychiatric residents are women at many teaching programmes) eyes to the patient's face, is a troubling one. However, the comprehensiveness, comparability (across patients and across time) and focus provided by this approach to interviewing now seems to me to have much to commend it. When this approach extends to manual based 'guidelines' (read: orders) for how patients should be treated, as a number of hospitals are increasingly attempting to do in the interests of 'quality control' (read: fear of litigation and/or denial of reimbursement) it is surely going too far. This 'medical' pole is associated with an insistence on biological factors in the aetiology, diagnosis and treatment of mental illness, whenever, wherever and however these may be found. Neurotransmitter assays, DST and other challenge diagnostic tests, neuroanatomical investigations by BEAM, SPECT, and the older established MRI and CAT, plasma psychotropic drug levels, among others, have taken over powerfully from phenomenologic and psychodynamic investigations and formulations. As a result, enormous numbers of investigations are conducted. The yield in terms of sheer data generated is considerable; the practical and theoretical value seems more dubious. One of the weaknesses of this emphasis is exemplified by books such as *The Good News about Depression* (Gold, 1987). In this, a sub-specialty designated 'biopsychiatry' is created and extolled, an index of its practitioners in each state in the USA is provided, and patients are encouraged to believe that special tests exist to diagnose not only their particular version of the 'biochemical imbalance' much alluded to by the media, but also to establish the medication type and even dosage that will be needed to repair this.

At the other pole of this first axis lies psychoanalysis. Its influence in clinical care, training, research and psychiatric politics appears from my own probably parochial perspective to have waned. I belong to the surely large group which considers that the contribution of the psychoanalytic frame of reference to the observation and understanding of the 'furniture of the mind' and the symptoms of our patients cannot be swept away by appeal to Popperian principles whether we take the leap of faith into

the belief in the existence of an Unconscious, or not. However, while the basic ideas are now readily accessible, recent American psychoanalytical writings have become abstruse to the point where the clinical psychiatrist becomes disillusioned and wonders what is in it for his management of patients. Perhaps the recent legal victory (American Psychoanalytical Association, 1988) by a group of psychologists requiring the psychoanalytical training institutes to provide full parity of opportunity for enrolment to suitable, non-medical applicants will lead to some much needed input of conceptual clarification and research (incidentally, this is not how the psychoanalysts construe this outcome!).

The second axis which might be regarded as orthogonal to the first, and as dealing with 'practice', extends between the poles of private practice and the practice of academic psychiatry. The former occupies approximately two-thirds of psychiatrists where they are found at the lower end of the medical profession earning scale (approximately $100,000 per annum after expenses but before taxes, slightly higher than those at the bottom, the general practitioners and paediatricians). One recent attempt to increase the value placed on 'cognitive' services such as those psychiatrists provide is the Resource Based Relative Value Scale (Merrill, 1988). This is a Harvard-designed procedure intended to take into account many of the factors that go into the training for and providing of a medical service in order, by a process of inter-specialty 'handicapping', to establish more equitable rates of reimbursement.

The psychopathological spectrum encountered in private practice is wide. I have seen very little of the situationally driven, encapsulated problem described in the Canadian population by Dr Crammer (1986). Certainly there are precipitants to the referral but there is also a high prevalence of premorbid problems and prior psychiatric history. I have never had patients who "come in order to make the best of themselves" or for "spiritual training". At $100 per hour, that would be a journey of salvation very few could afford.

Treatments provided in private practice are, in the majority of cases, of an eclectic type. While psychodynamically informed psychotherapy is also widely provided, this is most frequently done in conjunction with psychopharmacological management, a dual approach which has been as inadequately researched as widely practised, and which presumably embodies most closely the bio-psycho-social approach under which most psychiatrists would probably claim to practise.

At the other end of this second axis lies the academic pole. Salaries are mostly lower than earnings in private practice and tenure has been drastically reduced. The need to obtain grants to support research is constantly present and the competition is fierce. The description Dr Szmukler (1985) gave of Australian academics in his review ("... imagination, intellect, flair and energy ...") is certainly apt here, too. There is no secure place at this time (an Americanism for "now") for an academician who wishes primarily to teach and to treat, infrequently distilling some conclusions from his clinical experience in a short publication.

I also find very limited tolerance for the person in the centre of this second axis, who wishes to maintain both a private practice and an academic affiliation. My impression was that this was a not uncommon form of practice in the UK; certainly a number of my own teachers functioned in this mode, especially those with a psychoanalytical practice. But here, such a stance is viewed with suspicion by both sides. As a result, I have recently capitulated after five years of this dual mode of function and returned to a full-time position in the department of psychiatry at the local university. Whether this conflict between Town and Gown is an indication that the prescription against serving God and Mammon is taken more seriously in the New World or whether it is really derived from a clash of economic interests is uncertain. ...

The intersection of these two axes is illustrated at the Annual Meeting of the APA held each May for a week around the country in various large cities which vie for the lucrative convention business for years in advance. One recent such meeting in New York drew over ten thousand 'attendees', mostly drawn from the private practice community, who came together to listen to the academicians. The scale of these conferences, with hundreds of presentations delivered in lectures, symposia, papers, poster sessions, workshops, all summarised in a syllabus that approximates the size of the Manhattan phone book more closely each year, is such that extreme selectivity needs to be exercised if mind numbing is to be escaped. In practice this means attending one or two presentations specifically relating to new advances in the area of one's own special interest (although there are also many specialised organisations each with their own meetings which tend to cater for that), then to depart for the flesh pots of the pharmaceutical houses subsidised breakfasts where food and education are absorbed together or evening parties which are often organised around some major exhibition or performance. Somehow, one of the main purposes of the meeting, to provide a substantial portion of the 150 hours per three years of 'Continuing Medical Education' credits required for re-licensure, is met. Regretfully I have not attended one of the Royal College of Psychiatrists meetings for many years but my impression from the programmes I continue to receive is that they are more homogeneous in the manner in which the material is presented as well as in its quality, and hence are more readily digestible.

Around these two major axes are clustered numerous other areas of special concern. Two such are currently battlefields on which wars are being fought with victory for psychiatry in sight on one and defeat on the other. The former is leading to the gradual shrinkage of the power of attorneys to encourage juries to find vast sums for plaintiffs in malpractice claims. These claims have not been as outrageous in psychiatry as in some other specialties but are still sufficient that the average malpractice insurance premium for a policy now offered by the American Psychiatric Association is $5,000 per annum. Tort reform initiatives in several states launched by powerful political and fiscal manoeuvring by state medical associations have been won in many areas and are now beginning to take effect.

The defeat is one that appears to be imminent in the battle with the clinical psychologists. For some time they have provided psychotherapy and have done so at lower rates than are current among psychiatrists. Now the psychologists are moving in the courts to seek the additional right to have hospital admitting privileges and prescription writing powers. Demise rather than mere dissent appears to be looming on the horizon!

Does all this seem sufficient to account for the 'over-determined' look about most American psychiatrists I know? And there are other matters of note: the shortage of nurses, 'managed care plans', the impact of foreign medical graduates, the dementia and other psychiatric aspects of AIDS and the growing trend toward sub-specialisation within psychiatry. But those are issues on both sides of the Atlantic.

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A full list of references is available on request from the author.

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Conference report

Casting out demons?*

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A one day conference on possession and religious psychosis drew clergymen, doctors and other health care workers from across England and Scotland. It was organised by Sunderland Health Authority and papers were presented by churchmen and by psychiatrists, under the chairmanship of John Cox, Professor of Psychiatry at Keele University.

The Reverend Canon Anthony Duncan, the Vicar of Whitley Mill in Northumberland, opened the

*A report on the conference held on 26 April 1989 at the Roker Hotel, Sunderland.