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Some Pessimistic Reflections on the Present State of Psychiatry

Dr. Dorothy A. Starr, M.D.

What sound men combine, the good
must associate; else they will fall
one line, an unyielded sacrifice in
a unmistakable struggle — Edmund Burke. Thoughts on the
Cause of the Present Discontents.

Perhaps the most dangerous thing
about psychotherapy is that it is
too satisfying for too many people
too much of the time for too many
reasons. With the present rate of
proliferation of therapists and
therapies, and the current disdain
for the fine art of diagnosis, we seem
destined to spend ourselves quibbling
about who does what to whom.

The explosion of progress in the
last fifty years is totally dwarfed
by the explosion of problems "cry-
ing for solution." Currently it is
fashionable to look for and expect
cure for anything "bad" and a
distribution system to make available
to all, anything "good." Psychotherapy is about as well
defined as "quality medical care"
and just as highly touted. To chal-
lenge what is meant by either is
like being against progress and
relevance, innovative solutions
and creative programs. We are so
busy being "with it" that we seem
danger of trading our integrity
as physicians for popularity as
social reformers. We are so invested
in concern about poverty, racism
and violence that we have left
our public clinics and public hos-
pitals and the patients therein to
the care of indigenous workers
and other professions.

Psychiatrists have popularized
psychotherapy, deprecated the
somatotherapies, and made it as
profitable as it is prestigious to be
a psychotherapist. We didn't
spearhead the mental health move-
ment, our friends and admirers
did that, but psychiatry went down
the line with them as technical ad-
visors alleging that great things
could be done for society if there
was only enough money and man-
power for new programs. Money
was appropriated and new man-
power developed among the other
traditional mental health profes-
sions, psychology, social work and
nursing. And still there remained
great unmet needs. Newer pro-
grams followed — to train house-
wives and clergymen and hospital
attendants and indigenous workers.

On another front was the strug-
gle to gain acceptance of coverage
for mental disorders under health
insurance. This has been largely
successful in the Washington met-
ropolitan area where the federal
employees program and Medicaid
do include coverage for psychi-
atrie services, or perhaps I should
say, for mental disorders, for there
is the rub. It may take a psychi-
atriist to practice psychiatry but
apparently anyone can practice
psychotherapy.

Somewhere along the line, psy-
chiatry began to depart from the
medical model and here, as in
other facets of society today, we
threw out the old and substituted
nothing. It is now nearly impos-
sible to get any kind of a con-
sensus on what is to be included
in the label "psychotherapy" and
how it is to be defined; what is to
be included in the label "mental
disorder" and how it is to be de-
fined; who is to be included in the
label "psychotherapist" and how
he is to be paid.

First in our clinics and now in
our hospitals, we are encouraging
more and more people to take a
more and more active role in what
for practical reasons — we still call treatment of patients. I
emphasize this because just as
Thomas Szasz calls mental illness
a myth and continues to teach in a
medical school, the practitioners
of the non-medical models still
call their clients patients, at least
on health insurance forms. I may
be deluding myself but I continue
to maintain that I practice in the
medical model although I call it
family therapy and make much
use of the family interactional
model. I also prescribe medication
as indicated and recommend hos-
pitalization occasionally.

But what of the non-medical
psychotherapist? In today's world
of equal rights and concern for the
poor and the minorities, we can
hardly take the position that ther-
apists who are good enough to treat
our deeply troubled, multi-problem
inner city masses aren't good enough
for the more functional, better off
suburbanites. I formerly held (or
only rationalized?) that only the
medical therapist was fully qual-
ified to practice independently be-
cause only he had the requisite
medical background to provide
the ongoing medical surveillance
necessary. That position is unten-
able on two counts. One, it is the
clinic patient, the poor person, who
really lacks the ready and con-
tinuous access to general medical
supervision; the middle class pa-
patient has or can easily be sent to, his own internist or general practitioner. Secondly, since the American Board of Psychiatry dispensed with the requirement for an internship, I remain dubious about what will be the reality of the medical expertise of the new crop of psychiatrists. This leaves me with my remaining reason for distinguishing between the psychiatrist and even the very well trained and competent non-medical therapist, the simple fact that psychotherapy is only one of the treatment modalities for mental disorders.

Despite its overwhelming popularity, there is little hard data to prove the effectiveness of psychotherapy. Certainly, it has contributed little to our most favorable statistic— the declining mental hospital population. This must largely be credited to the drugs and to changes in community attitudes and services.

It used to be taught that psychotherapy was work for the patient as well as the therapist. To make a good therapy case it took a well motivated patient with considerable ego strength consciously willing to undergo psychic discomfort for long range goals. Now, with health insurance, we see that a well motivated therapist is sufficient. In fact, although there are still large numbers of people who find psychiatry threatening and the therapy process alien, there are greater (and growing?) numbers who, once introduced to it, find therapy quite pleasurable. The process of keeping regular appointments with an impressive expert for the purpose of concentrating on the self, offers quite a lot of gratification.

Folklore has always recognized that people enjoy talking about themselves to an interested audience. In this geographic area where we have a sophisticated population with health insurance coverage and sick leave, psychotherapy is practically a fringe benefit. If it garners any more acceptance, we may have launched the shorter work week.

Now we have more problems. We have just had our first round of revelations about Medicaid payments including over $100,000 in one year to a psychiatrist. This was quickly followed by reports of large Blue Shield payments to others. Some of these will prove appropriate, some dubious, and some may turn out to be fraudulent overutilization. But where will the lines be drawn, and who will do it? Have we already defaulted on our responsibility and our claim to police our own ranks? I think so. I think for reasons of convenience, disinterest, preoccupation, and business, and a reluctance to risk unpopularity, criticism and enmity implicit in taking a stand, we have compromised, appeased and adapted. Since I am concerned about my integrity, not the other doctor's and certainly not yours, I am now forced to rethink about my own practices as a psychiatrist. First, in dealings with the Third Party I can no longer hide behind the rationalization that the insurance contract is between patient and carrier and not my concern. He who pays the piper will inevitably call the tune. I am unwilling to have the computer determine the treatment of my patients on the basis of some norm for the diagnosis, without active—if unsuccessful—intervention on my part. I must at least try to avoid getting into the bind where I make the diagnosis fit the treatment plan, or treat the patient inadequately.

Since the subscribers are the buyers both of the insurance and my services, my services should include educating them so that they can make knowledgeable choices. For me this means that I have begun to inform my patients that Family Therapy, as I do it, mostly seeing couples, is not openly covered by most carriers. For my part, I will now indicate on the statement which is seen, after serving notice to the major carriers that this is a reputable, accepted psychotherapy technique, and request that they inform me if they intend to disallow it so that their customer can decide whether to change insurance plans or change doctors.

Further, I see a responsibility to work through to a clearer definition of my own services in terms of what I mean by mental disorder and what I include in psychotherapies and somatotherapies. I may not personally use all modalities of treatment but I know I am better qualified to judge their validity than some clerk in an insurance office. Toward that end, I am drafting a working paper to be submitted to the local psychiatric society proposing that we take the initiative in telling the insurance carriers what we consider customary and reasonable psychiatric services, instead of lying to react to what they adjudge to be "overutilization" or fraudulent claims. In addition to the commonly accepted somatotherapies and psychotherapies, I would propose and plead for a category for new and experimental therapies for which a protocol might be advisable. This is not a new idea, following as it does along the lines of the relative value fee scales, but psychiatry has been remiss in not putting one forward in my area.

Much more difficult will be attempts to define "mental disorder," but here again, I prefer the initiative even if I have to be a single voice on the record. I do not wish to sit by as we largely did with alcoholism until the courts adjudicated it to be a mental illness. We can surely at least take action to insist upon adding drug abuse to the allowable diagnosis for treatment rather than hiding behind some euphemism such as the "underlying psychiatric disorder."

Then there are the matters falling under the headings of peer review, standards and ethics. Much of this is already spelled out and more will be, but largely under pressure from the outside—chiefly carriers, governmental groups and patients. In my experience, it has not been customary, nor expected, for physicians to initiate inquiry. I think this has been an error of omission that has badly served
ourselves and badly damaged our public image. This is particularly true in psychiatry and especially in psychotherapy, where, by trade, we use our professional skills to establish a significant, often intensive, relationship with another person at every time when his defenses and controls may be most vulnerable.

Recently in our society we had a case which involved allegations that the psychiatrist had engaged in sexual relations with patients. The membership voted against the recommendation of the ethics committee and the Council that the member be disciplined. I do not dispute the decision, but I do consider it ducking the issue. Do not most by-laws of medical societies provide for appeals to the membership or for approval of the membership? Should not the two questions be separated so that the peer group is asked to rule on the ethical question as well as the guilt?

In the case I mentioned, I think that the membership, or at least the miniscule portion of it that turns out for such meetings, should have been asked to take a stand, for the record, either that sexual relations between psychotherapist and patient, while a doctor-patient relationship exists, do constitute exploitation of the transference and unethical behavior, or do not. In this way, a vote against disciplining the member for lack of satisfaction that the allegations have been proved, will not be misconstrued as endorsing such behavior. This course could serve to educate members as to the local society's stance since that is the standard by which we are to be judged.

But I would prefer to go one step further. I would like to see it become customary for our professional groups to initiate inquiry about members when they, in their professional activities, are subject to adverse publicity or are privately criticized to others of us, in order that we can knowledgeably defend a member whom we exonerate, or take a stand against dubious or unacceptable practices. Until then, the notion of policing our own member seems spurious. We generally wait until someone else catches him stealing from the poor box. After he's been tried, convicted, exhausted all possible appeals, and on his way to jail, we convene to reprimand him.

I found two recent experiences along this line discouraging confirmation of this. In one, the outlined course was followed and the society concerned met in a special meeting to affirm a reprimand for admitted charges after the exhaustion of all legal appeals—now several years after the complaint was filed and during which the laws were changing. To me this smacked of that old story about the man who murdered his parents and then threw himself on the mercy of the court because he was an orphan.

In the other, consistent with the position I deem reasonable, I took the action of formally making the motion that the Chairman of the Department be asked to investigate the allegation that a fellow staff member had collected $106,000 in Medicaid payments during a twelve-month period, during which he was said to have held a half-time job with the local health department. These allegations were front-page news in the morning newspaper. Presuming our colleague to be an ethical practitioner, I would have liked to have had the department take note of this adverse publicity and offer him an opportunity to acquaint us with the correct facts or an explanation if possible. Given the number of hours in a day and the local rate of Medicaid payment, the total remuneration seemed inconsistent with good psychiatric practices and the contractual agreement for physicians participating in Medicaid.

The matter is of course under investigation elsewhere and given the usual rate of such proceedings, we seem to negate entirely the notion of policing ourselves if our action is always to be delayed until the ponderous wheels of justice have reached the point of unappealable judgment. Nonetheless, I was more dismayed to learn that several of my colleagues took the position that how a man makes money in his medical practice outside of our hospital is not our concern. I vehemently reject that position, for me it is untenable.

The Medicaid case points up, of course, another problem for the future of psychotherapy if anyone can afford it. The elderly, for example, do not make proportionate demands for psychotherapy consistent with their numbers. I can easily make a case for the desirability of encouraging them to utilize outpatient service in the hope, or on the theory, the supportive psychotherapy in the community would decrease the mental deterioration that leads to mental hospitalization for so many elderly people. But before we get to widespread use, should we not see the problems it would also bring? If we don't, are we not setting the stage for another round of revelations in which the psychiatrist is pictured by the press as exploiting hopelessly elderly people with treatment they can't use for inordinate profit at public expense?

I have one elderly patient who started in psychotherapy with me seven years ago, and my best efforts have not averted a gradual downhill course. Mrs. X. now has such severe memory impairment that it is unlikely that she can mobilize her failing energies for other activities and she has become dependent on the supportive psychotherapy. To terminate her seems destructive, to continue her seems somewhat inappropriate. Not that psychotherapy isn't useful, but that these particular services could be provided equally by a non-medical therapist (the patient has an excellent internist looking after her medically), or even a sympathetic clergyman who could give her regular time. But she started with me and resists a change and a consultant concurs that she should continue.

One, or even a few such ineliminable cases, (especially if, as in this lady, there is no financial problem and no Third Party to
considered is well and good, but should this become the standard for psychiatric care available to all? In a sense this raises the general problem first noted by Freud—therapy, terminable or interminable. It is not only the elderly who can become established in support psychotherapy. Termination in psychotherapy seems to me like toilet training. If you catch the subject at the ideal moment which is “the soonest he is ready for it and before the pleasurable quality has been too long enjoyed,” to paraphrase a comment by Therese Benedek. But, for psychotherapy — too soon, it won’t work and too late, it won’t happen.

I have alluded to the matter of the non-medical therapist elsewhere, but not really dealt with it. There is some merit in the argument put forth by some of them that it is not their merits as psychiatrists that psychiatrists question, but their competition. We use them and their expertise, as I have mentioned, to the fullest in salaried positions, and then challenge their competence when they want to move out into the community as private practitioners of psychotherapy. I now think that with current trends, there is a valid role for them in the private sector as well. This does not change the position I took some years ago in congressional hearings on the D.C. Licensure of Psychologists Bill, to wit, that the public need was, and is, for protection from untrained quacks. I recommended rather that there should be a bill to license all non-medical psychotherapists with standards and boards to be drawn up by each of the professions involved. I would go further now and add that I am neither for nor against their inclusion in any insurance program as a separate, non-medical service that indeed can contribute to health maintenance. I see this as a matter that should be decided between the public, the carrier and the other disciplines. I think our services can stand on their own merit, and if they can’t, they should fail. The medical model has been maligncd. It is not malicious, nor is it inadequate to the psychiatric practice of psychotherapy in many modes. I think the time has come to stand up and be counted rather than to stand by and be dishonored and dismissed.

The only thing necessary for the triumph of evil is for good men to do nothing. — Edmund Burke, Letter to William Smith.

REFERENCES:

A NEW PRIESTHOOD?
George A. Kanoti, S.T.D.

Ministers of religion and psychotherapists are two groups of professionals especially concerned with the meaning of human behavior. Like the hoary story of the two blind men who were directed to touch opposite parts of an elephant and then were asked to describe the pachyderm, each has a different tale to tell. Each professional has a different explanation of the meaning and significance of human behavior.

The minister of religion sees the significance of human behavior in its relationship to religious fulfillment or salvation. In his eyes behavior which contributes to man’s achievement of religious fulfillment or salvation is good and desirable; whereas, behavior which hinders man’s attainment of salvation is evil and undesirable.

The psychotherapist, on the other hand, has a different view. He sees the significance of human behavior not in terms of its relationship to religious fulfillment, but in terms of its relationship to normality, maturity, or personal fulfillment. Behavior which encourages maturity or personal fulfillment and expresses normal behavior is good, appropriate or desirable; whereas, behavior which prevents advancement in maturity or personal fulfillment is considered abnormal, inappropriate or un-

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