Therapeutic practice profiles, work settings and activities of Swiss psychiatrists

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Summary

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There is a growing interest for issues concerning therapeutic practices in psychiatry, but the respective importance of different approaches and the combinations of the practices psychiatrists might use remain largely unknown. From a survey among Swiss psychiatrists, the general structure of their practice patterns can be drawn. Psychiatrists deploy a wide-ranging blend of different therapeutic practices. Out of these combinations, four very distinct therapeutic profiles can still be observed: psychoanalytic, biological, systemic and cognitive-behavioural. A last group, called general orientation, presents a practice structure which does not match any of the preceding references. Psychiatrists belonging to these distinct therapeutic profiles differ in their work settings as well as in their activities.

Compared to other international studies, results concerning Swiss psychiatry demonstrate that within the psychiatric field, the psychoanalytic reference holds an original position of interface between the public sector and private practice. On the other hand, biological psychiatry is markedly present within psychiatric institutions and plays a leading role in teaching and research. These orientations coexist, however, with other theoretical references forming a diverse tableau of psychiatric activities and practice settings.

Keywords: psychoanalysis, biological psychiatry, systemic psychiatry, cognitive-behavioural therapies, eclecticism, therapeutic practices, work settings, activities

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Résumé

Profils des pratiques thérapeutiques, cadres de travail et activités des psychiatres suisses

Si les débats portant sur les pratiques thérapeutiques en psychiatrie connaissent un intérêt croissant, l'importance réelle des différentes approches et leurs éventuelles combinaisons par les psychiatres restent très largement méconnues. Une enquête réalisée auprès des psychiatres suisses permet de brosser un tableau d'ensemble de leurs pratiques thérapeutiques. Les psychiatres font souvent un panachage de thérapies aux références théoriques parfois différentes. Quatre profils très clairs peuvent toutefois être décelés dans leurs combinaisons de pratiques: les profils psychanalytique, biologique, systémique et cognitivo-comportemental. Un dernier groupe, dit généraliste, ne se distingue par aucune approche spécifique. Les psychiatres appartenant à ces différents profils se différencient dans leur insertion professionnelle et leurs diverses activités: cliniques, de formation, de recherche et d'enseignement.

Comparés à d'autres études faites sur le plan international, les résultats concernant la psychiatrie suisse mettent en évidence que l'orientation psychanalytique occupe dans le champ psychiatrique une position originale d'interface entre le secteur public et la pratique privée. Au contraire, la psychiatrie biologique est fortement implantée au niveau des institutions psychiatriques et assure de façon prépondérante l'enseignement et la recherche. Ces orientations coexistent cependant avec d'autres références théoriques en formant ainsi un tableau très diversifié des activités et des cadres de travail psychiatriques.

Mots clé: psychanalyse, psychiatrie biologique, psychiatrie systémique, thérapies cognitivo-comportementales, éclectisme, pratiques thérapeutiques, cadres d'insertion professionnelle, activités

Introduction

Numerous studies on the different aspects of psychiatric practice show that the activities of psychiatrists have been significantly transformed in recent years. Fenton et al. [1] have drawn attention to the following factors: diversification of practice settings and clienteles, extension of the psychiatric sector and the modification of its relations with somatic medicine, plus changes in the health insurance and general health care systems.

As other studies demonstrate [2–5], the major activity of psychiatrists is direct patient care. But one notes a distinct trend towards greater involvement in other activities (supervision, consultancy, teaching and training) apart from research. The work of today's "average" psychiatrist is split into a greater number of activities carried out in a greater number of settings [1]. Thus the mean number of psychiatrists' work settings rose from 1.7 in 1965 to 2.3 in 1979, and the number of different activities from 2 to 2.7, a trend which has been confirmed by Dorwart et al. [6].

Langsley and Yager [7] also report substantial changes since 1980 in therapeutic practices – the advance of biological psychiatry, remedicalisation of psychiatry, new approaches in psychotherapy, less recourse to long-lasting therapy in favour of brief therapy and crisis intervention, breakthrough by other professionals (psychologists, social workers, counsellors) in the psychotherapy field, changing recourse to third parties. Psychiatric practice has thus evolved towards greater diversification which is itself linked to the multiplication of theoretical references [8–10].

Beitman et al. [8] have listed over 400 different forms of individual psychotherapy, to which must be added group techniques, couple and family therapies, and the interventions deployed in broader (e.g. institutional and community) settings. It appears, however, that each country or geographical region is characterised by the predominance of certain therapeutic forms, such as, for example, mixed treatments, diagnosis and subsequent therapy referral, and pharmacotherapy, for Spanish psychiatrists working in the public sector [11], or long-term therapy and support therapy as used very frequently by Texan psychiatrists in preference to individual psychotherapy [12].

The tendency to promote combined therapies is becoming more and more pronounced [13]. Redlich and Kelert [14] had already shown in 1978 that about 40% of the patients undergoing psychotherapy from Connecticut psychiatrists were also receiving medication. Heim [15] arrives at the same conclusion. Kane and Harper [12] found no significant difference between psychoanalysts and non-psychoanalysts as regards the prescription of anxiolytics and anti-depressants. Like Post [16], Donovan and Roose [17] instance the advantages of combining medication with psychoanalytic therapies chiefly for affective disorders.

Finally, the place of psychiatry in a health system fraught with change is being increasingly debated at several levels. However, because most studies cited draw on limited contexts, they only provide part of the answer on this score. Debate has been constrained by the paucity of research into psychiatric practice for countries as a whole. The only means whereby findings and conclusions can be generalised for the psychiatric profession at large and a precise idea can be gained of the different practices is to conduct studies at a national level.

The aim of the study from which we are presenting the results was to assemble systematic information on various aspects of psychiatry in Switzerland. We shall be focusing in this article on therapeutic practices and seeking to answer the following questions: which of the therapeutic approaches are used the most and the least? Are Swiss psychiatrists characterised by a homogeneous practice structure, or, alternatively, is it possible to identify practice profiles in which they might differ from one another? And lastly, which activities and work settings are significantly associated with these profiles?

Material and methods

The results come from a survey of all the psychiatrists in Switzerland conducted by Geneva University's Department of Psychiatry in conjunction with the Swiss Psychiatry Society and the Swiss Society of Paediatric and Adolescent Psychiatry. It took the form of a questionnaire mailed to about 2300 graduate psychiatrists established in private practice or working in institutions. There was a response rate of 44%, and 971 out of the 1000 questionnaires returned (between November 1994 and January 1995) were used for this analysis. The questionnaire was chiefly concerned with the psychiatrists' professional activities (work setting, number of hours worked a week, time spent on different activities, clinical practices, etc.) and their theoretical orientation, areas of interest and representations of psychiatry.

If gender, the region of Switzerland from which the individual comes, as well as the different specialisations (psychiatry and psychotherapy on one hand and child and adolescent psychiatry on the other) are taken into account, it would seem that

the sample that we obtained is representative of the whole group of Swiss psychiatrists (Secrétariat FMH [18]). Consequently, it can thus be considered that the different therapeutic practices are also adequately represented.

Three questions sought to elicit therapeutic practices. The first related to the therapies psychiatrists use with individuals, listing the main forms of treatment according to orientation, i.e. psychoanalytical, pharmacological, cognitive-behavioural, systemic, etc. The second asked about therapies with families, couples and groups, and the third concerned more specific practices. The psychiatrists were asked how often they practised each of the therapies, i.e. never, rarely, fairly often, very often.

Results

The first section on the results is a presentation of the general data on Swiss psychiatrists' socio-demographic characteristics, activity sites and types of activities. We shall then go on to describe the five therapeutic profiles around which this analysis of the results revolves, and show how they relate to psychiatrists' work settings, activities and clinical work.

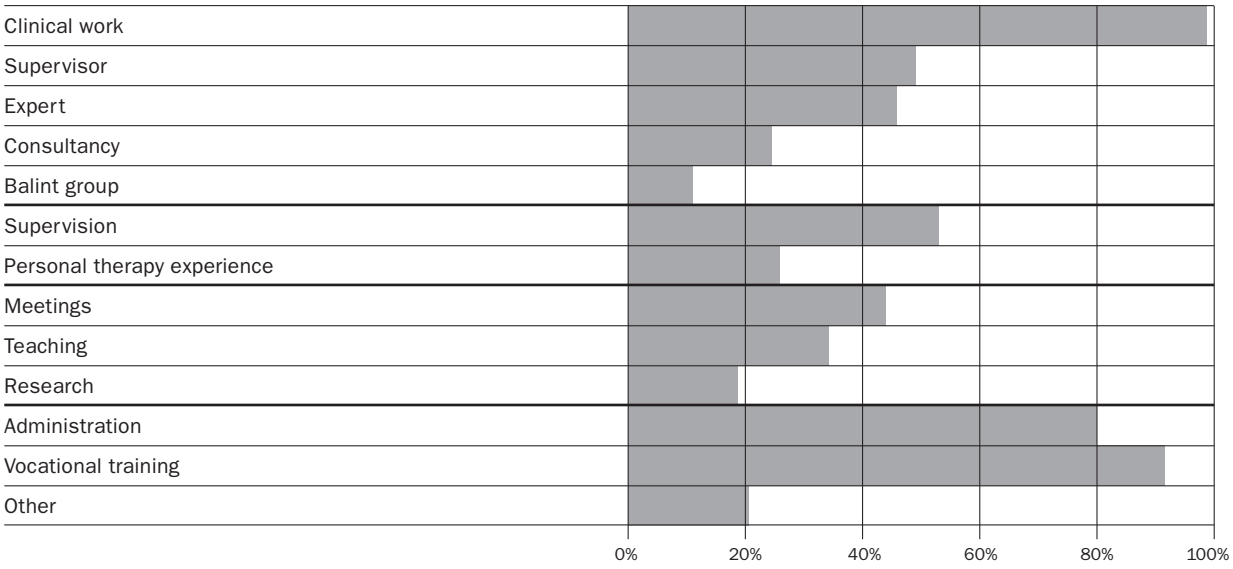


Figure 1
Percentage of psychiatrists mentioning the different activities.

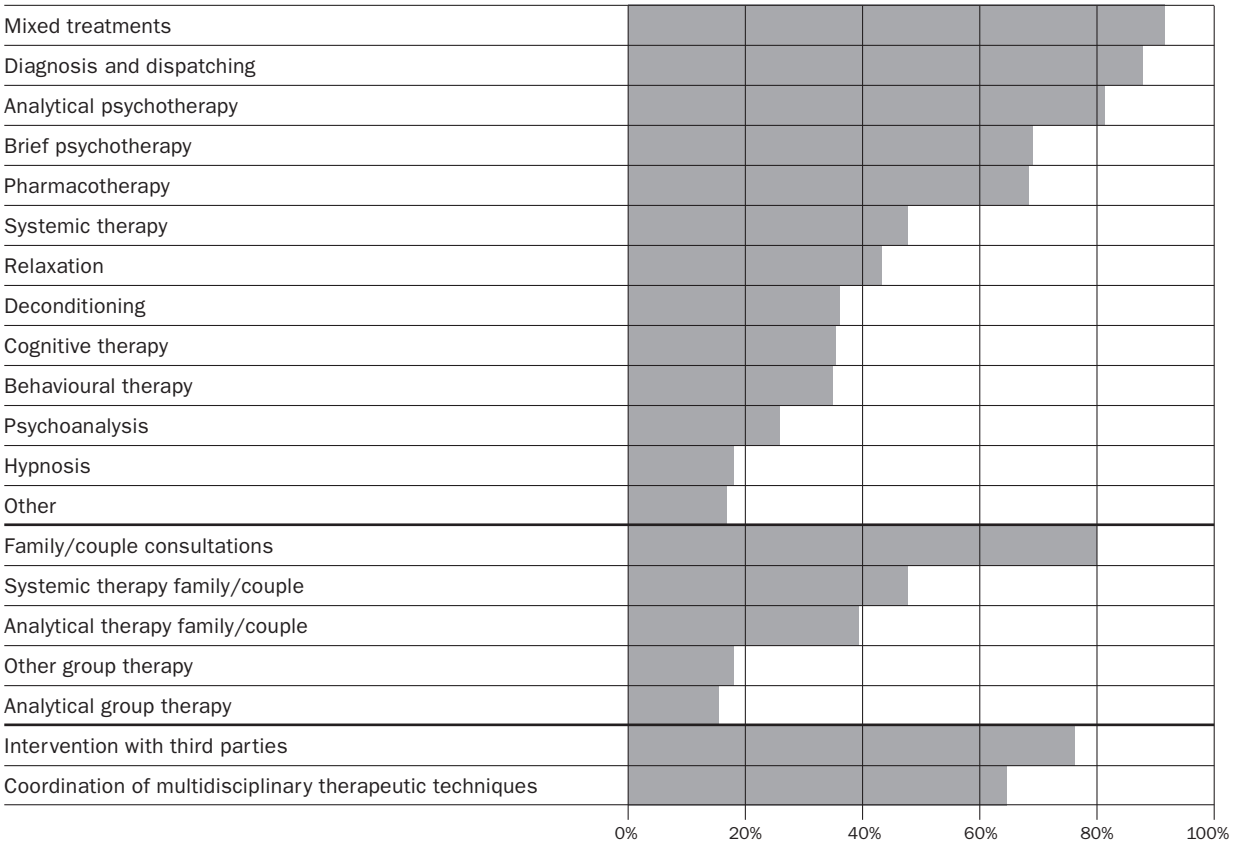


Figure 2
Percentage of psychiatrists employing the different therapies.

General characteristics of Swiss psychiatrists

Turning firstly to the socio-demographic aspects, one finds that almost a third (31%) of Swiss psychiatrists are women. The age structure is characterised by a predominance of the middle age group: 21% are under 40, 45% between 40 and 49, 20% between 50 and 59, and 13% 60 or older. From the point of view of regional dispersion, more than two thirds (68%) are in German-speaking Switzerland, 29% in the French-speaking cantons and 3% in the Ticino. A majority of Swiss psychiatrists (68%) hold the FMH qualification in psychiatry and psychotherapy. Almost one in ten (10) is qualified as psychiatrist and psychotherapist for children and adolescents. Five per cent are doubly qualified as specialists, but 18% have no qualification. The period of resident training is five and a half years. The average length of time that psychiatrists have held a hierarchical position is close on 5 years.

Almost a third (30%) of Swiss psychiatrists work solely in private practice; a fifth (22%), in addition to their private practice, also act as supervisors or consultants for colleagues or institutions for a limited number of hours a week, and 15% have activities in the private and public sectors in more or less equal proportions. Thus a total of two thirds of psychiatrists are engaged, either solely or partially, in private practice. Of those who work in institutions, 15% are in the ambulatory/outpatient sector, 12% in hospital services and 6% work in both. Of this 33%, 30% are in hierarchical positions and 3% are residents. This last figure is low as only residents who have finished their studies were included in the study.

On average psychiatrists work 47.2 hours a week, within extremes ranging from a few hours to 90 hours. Almost half (49%) put in over 50 hours week. Expressed as a percentage of the psychiatrists who assume a number of different activities it appears (figure 1) that virtually all (98%) Swiss psychiatrists have a clinical activity which represents the greatest part (61%) of their working time. Almost half act as supervisors or experts, a little over a tenth run Balint groups, about a quarter do personal therapy experience and almost half are having supervision. The percentages of psychiatrists in the activities most closely linked to institutional and university settings are as follows: meetings 43%, teaching 34%, and research 19%. Almost all the psychiatrists mention work connected with administration and in-service vocational training.

Construction of a typology of therapeutic practices

Figure 2 shows the frequency with which Swiss psychiatrists use different therapies. At this first level of analysis our interest is in whether various treatments are practised or not; the frequency aspect of their use will be considered in the following chapter. The results show that there is a very high diversity of clinical approaches (individual, family, couple or group, and specific activities) and theoretical references (psychoanalytic, biological, social, systemic, cognitive). By way of illustration, 92% of psychiatrists carry out mixed treatments, 81% practise analytically inspired psychotherapies, 80% family or couple interviews, 47% systemic therapies, 35% cognitive therapies and 76% interventions with third parties. These figures indicate that the different theoretical and therapeutic movements are widely represented in Swiss psychiatry, but with a certain predominance of psychoanalytically inspired therapies and pharmacological treatments.

But these findings also suggest that the different movements not only coexist within psychiatry as a whole, but also between the psychiatrists themselves, with each one seeming to deploy a very wide-ranging blend of the different practice forms and references. One finds in fact that the vast majority of them make simultaneous use of psychotherapy + medication pharmacotherapy, psychoanalytic therapies, brief psychotherapy, family or couple consultations and socio-institutional approaches (interventions with third parties, co-ordination of multi-disciplinary techniques). These six practices constitute the common denominator so far as the therapeutic activities of Swiss psychiatrists are concerned.

These first results might lead one to believe that Swiss psychiatrists, taken as a whole, undertake treatments which are so homogeneous, drawing as much on one reference model as any other, that it would be impossible to arrive at more specifically differentiated profiles and orientations. In order to be able to distinguish between typical activity profiles we carried out a factor analysis which took into account all the therapies and the frequency of their use by psychiatrists. This factor analysis came up with 5 factors which, taken together, account for 54% of the total variance:

1. Systemic therapies (21% of the variance) which chiefly comprise: systemic therapy with individuals, systemic-inspired family or couple therapy and consultations with families/couples.

2. Cognitive-behavioural therapies (10% of the variance): behavioural therapy, cognitive therapy, deconditioning therapy, hypnosis and relaxation.
3. Medicinal therapies (9% of the variance): chiefly medicinal treatment, mixed treatment (medication and support psychotherapy), diagnosis and therapeutic referral.
4. Psychoanalytic therapies (8% of the variance): psychoanalysis, analytically-inspired psychotherapy with individuals, analysis-inspired family, couple or group therapy.
5. Other therapies (7% of the variance): other individual and group therapies.

The results of this factor analysis show that psychiatric practice can be broken down into four orientations stemming from the first four factors. These have been used to draw up more precise professional profiles so as to provide a more highly differentiated description of the therapeutic activities. In order to be able to attribute just one therapeutic profile to each of the psychiatrists in our sample we have chosen the following methodological procedure. For a psychiatrist to be classified in any one of the four profiles which reflect clearly identifiable theoretical references (systemic, cognitive-behavioural, biological or psychoanalytic) he or she must satisfy two criteria. Firstly, in terms of frequency, he must have put down no less than "fairly often" or "very often" for the therapies under the factors. And secondly, that being the case, the orientation concerned must apply to at least a third of all his therapeutic activities. Thus when a practitioner comes under a particular therapeutic orientation, psychoanalytic for example, that means his practice ranks as typically psychoanalytic in terms of the frequency with which he uses these therapies and the major part that they play in his clinical activity. All the psychiatrists who do not meet the two criteria for any of the four profiles have been grouped in the "general orientation" category. Swiss psychiatrists are thus distributed among the following care profiles:

	n	%
Systemic practice	144	15
Cognitive-behavioural practice	51	5
Psychoanalytic practice	238	25
Biological practice	284	29
Generalist practice	254	26

These profiles do not mean that the psychiatrists they describe only practise these therapies. Systemic psychiatrists, for example, use systemic therapy predominantly and significantly more often than the others, but they also do mixed treatments, cognitive-behavioural, psychoanalytically inspired therapies, etc. These are, however, significantly under-represented in their practice. The same applies to all the other therapy orientations apart from the general category.

Therapeutic practice profiles

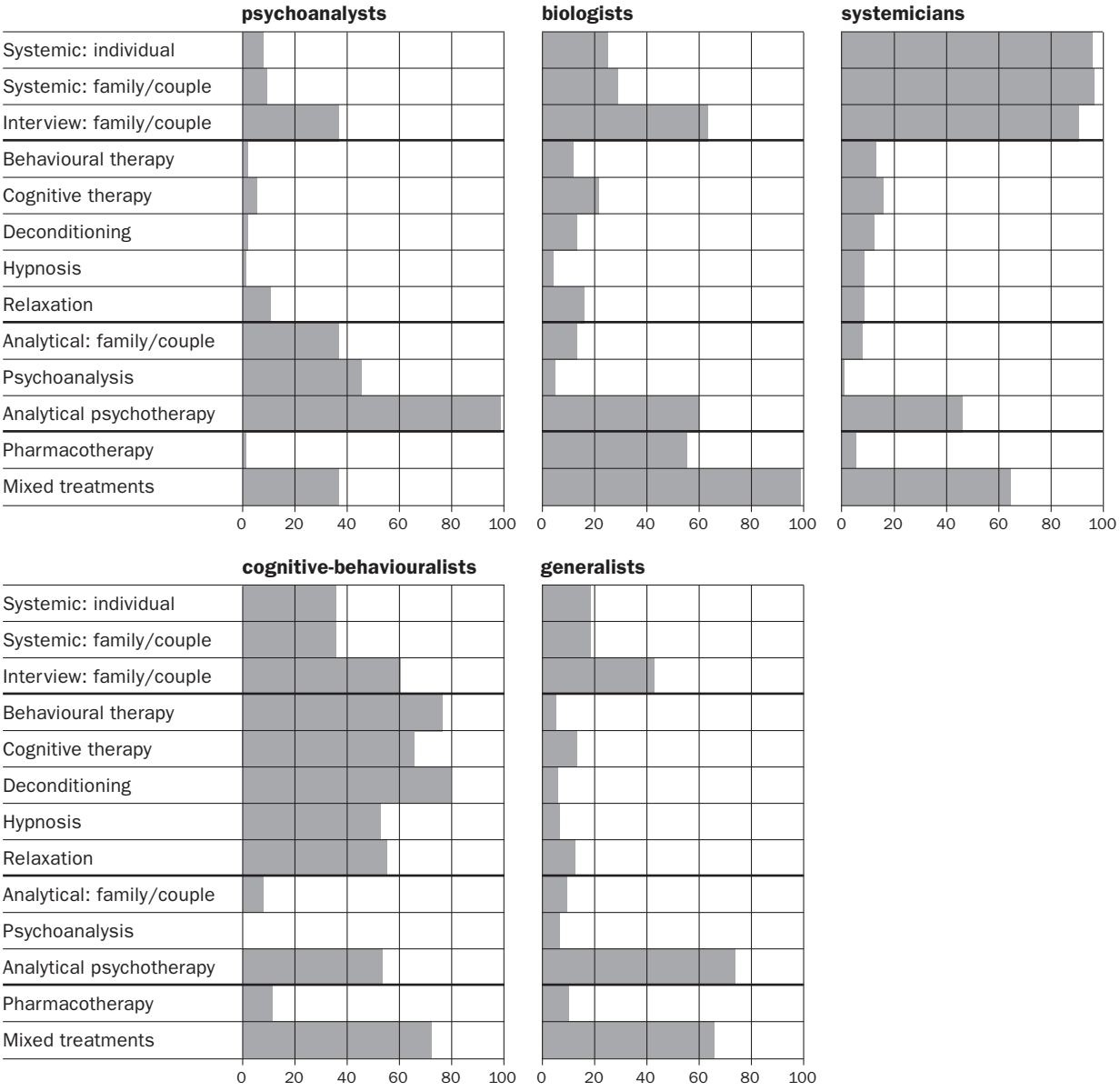
What distinguishes these different profiles? What are their underlying theoretical references? In order to answer these questions we studied the clinical activities as a whole by relating the practice profiles to each of the forms of therapy in the questionnaire. Figure 3 shows that these profiles are quite distinct from one another. Contrary to the initial impression given by figure 2, Swiss psychiatrists clearly fall into 5 groups in terms of the preponderance of the therapies that they practise and, conversely, the poor showing, if not absence, of other clinical approaches. It should be stressed that for each profile the dominant traits differ significantly ($p < 0.001$) from those of the other profiles.

The sharpest profile is that of the 238 psychoanalyst psychiatrists (figure 3). Virtually all of them practise psychoanalytically inspired psychotherapies and almost half carry out psychoanalyses. They do more practice with individuals than the other profiles, but over a third of them record carrying out psychoanalytically inspired therapies for families and couples. Apart from mixed treatments and family or couple interviews they rarely practise the other forms of therapy. This psychoanalytic therapeutic profile is therefore well centred on approaches which explicitly refer to the psychoanalytic model.

The profile of the biologist psychiatrists which applies to 284 psychiatrists is more characterised by mixed treatments (nearly all use them) than by pharmacotherapy as such. But almost two thirds of them do resort to family or couple consultations and to psychoanalytically inspired psychotherapy. What is more, about a quarter of them practise systemic approaches, with individuals and with families or couples, and cognitive therapies. Far from confining themselves solely to the biological model they thus extend their practices by including both systemic and psychoanalytic therapies.

The 144 psychiatrists affiliated to the systemic model present a therapeutic profile which very clearly draws on systemic therapies with individuals, families and couples, and family or couple

Figure 3 Percentages of psychiatrists employing the different therapies according to their therapeutic profiles.



consultations. Almost two thirds of them also do mixed treatments and nearly half practise psychoanalytically inspired psychotherapy. They only very occasionally resort to other forms of treatment and do practically no psychoanalysis.

The 51 psychiatrists in the cognitive-behavioural group have a much more heterogeneous profile. Needless to say, the forms of treatment in this theoretical reference category predominate: over two-thirds use behavioural therapies, cognitive therapies and deconditioning. This is also the group of psychiatrists which makes the most use of relaxation and hypnosis. But nearly three-quarters of them also resort to mixed treatments and nearly two thirds to family or couple consultations and psychoanalytically inspired psychotherapy. They also include an appreciable proportion (over a third) who use the systemic approach. Conversely they entirely exclude psychoanalysis and only very rarely resort to pharmacotherapy and psychoanalytic therapies with families or couples.

Lastly, the 247 generalist psychiatrists (figure 3), i. e. those whose profile does not match any of the four theoretical references, present a practice structure which tallies in every respect with the ruling tendencies of Swiss psychiatry in general. Three-quarters practise psychoanalytically inspired psychotherapy, two-thirds mixed treatments and almost half family or couple consultations. All the other forms of therapy are represented but to a lesser degree.

Profiles of therapeutic practices, activities and work settings

Before we flesh out the care profiles with data on psychiatrists' activities and work settings it should

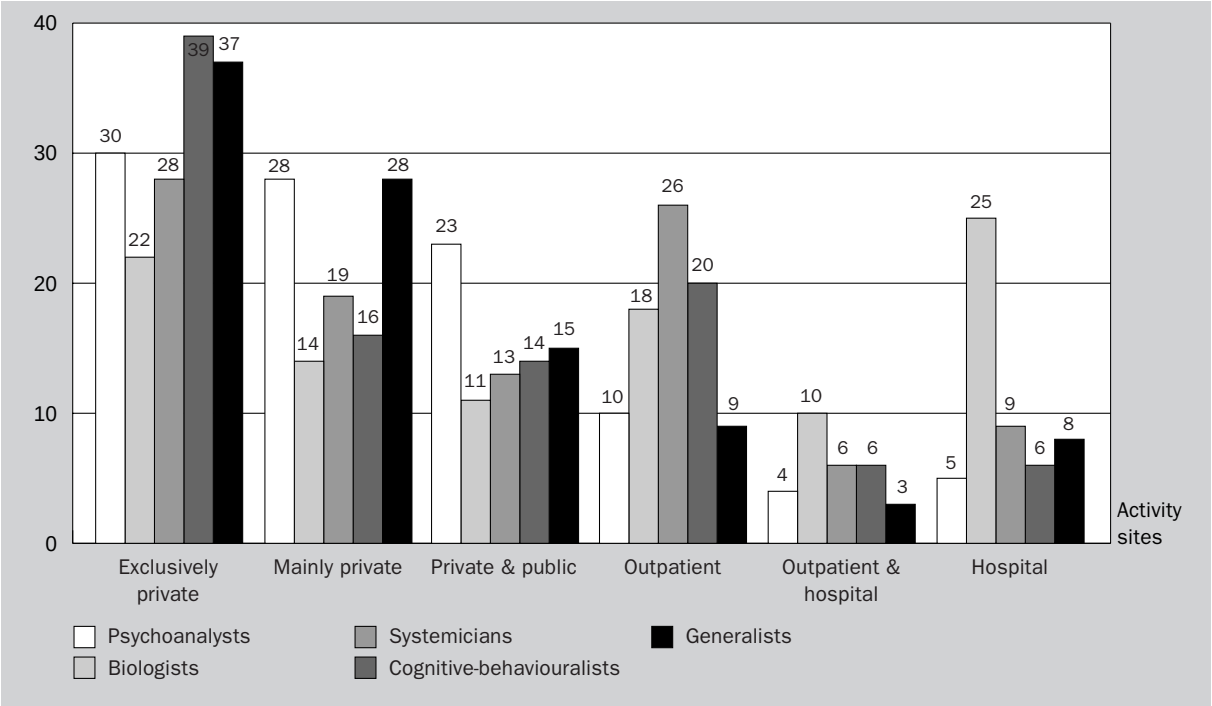
be said that these profiles do vary only slightly in terms of their socio-demographics. There is significant over-representation of women among the generalists and of men among the biologists. Where age is concerned there is a significant under-representation of psychoanalysts in the youngest age-group (under 40) whereas hardly any of the systemicians are aged over 60. The latter are to be found slightly more often in German-speaking Switzerland, and in places with populations of less than 30,000. The biologists, on the other hand, are more densely located in French-speaking Switzerland.

When it comes to the different activities, one finds significant differences among psychiatrists according to their therapeutic profiles. Hence the generalists ($p < 0.05$) and the psychoanalysts ($p < 0.001$) devote considerably more time to clinical activities. What is more, psychoanalysts act more often as consultants or supervisors ($p < 0.01$) and invest distinctly more time in their training and personal therapy experience ($p < 0.001$). In comparison with the other psychiatrists, the biologists ($p < 0.001$) spend the highest proportion of the total time on teaching, research and meetings, but these activities are largely under-represented among the generalists and psychoanalysts.

Allowing for all the activities which constitute services for patients (clinical work, expertise), colleagues and students (supervision and consultancy, Balint groups, teaching) and institutions (meetings, research), one finds that Swiss psychiatrists have, on average, 3.4 different activities. The biologists and systemicians account for significantly more than the average, i.e. 3.9 ($p < 0.001$) and 3.7 ($p < 0.05$) respectively, and the generalists significantly less (3.0, $p < 0.001$). The higher average figures for biologist and systemic psychiatrists are mainly attributable to a greater frequency of meetings, teaching, research and expertise.

This variation in activities undoubtedly partly reflects the differences in where the therapeutic profiles are professionally employed. As figure 4 shows, apart from the biologists, all the other therapeutic profiles are mainly in private practice, possibly combined with other professional employment. But it is primarily the generalists (79%) and psychoanalysts (81%) who are based in private practice, with the psychoanalysts also being the greater number to share their work with the public sector. Biologist psychiatrists are under-represented in private practice. The majority of them (53%) are in the institutional, ambulatory and/or hospital psychiatric services. The systemicians, on the other hand, are more frequently employed in the ambulatory sector (26%), much like the cognitive-behaviouralists (20%) who, along with the generalists, are proportionally the most numerous of the psychiatrists to work exclusively from a private office base. It is also worth noting that greater numbers of biologists, systemicians and cognitive-behaviouralists occupy high-ranking or middle-ranking hierarchical positions, with high-ranking defined as the exercise of the three functions of conducting meetings, teaching and research, and middle-ranking defined as the exercise of two of these three functions.

Figure 4 Distribution of psychiatrists' activity sites according to their therapeutic practice profiles.



Discussion

Predominant practices

Swiss psychiatrists characteristically have a very broad range of practices drawing on highly diverse theoretical models: over 90% do mixed treatments (psychotherapy and medication) with individuals, over 80% do analytically inspired psychotherapy, and over two thirds practise short-term psychotherapy. Pharmacotherapy is practised in the same proportions. Almost half have adopted systemic therapies, and cognitive-behavioural therapies have been used by over a third. There is a similarly diverse pattern for family, conjugal and group treatments. These practices appear to form the core of the activities of Swiss psychiatrists, based on a number of theoretical references, namely, medico-biological, psychological-psychoanalytical, systemic, cognitive-behavioural and socio-institutional.

Swiss psychiatry presents a number of novel traits compared with the findings of other studies. Because important differences exist between the health systems of different countries, the greatest care must be taken in comparing them. Nevertheless, these comparisons provide informations on distinctive characteristics of the psychiatry of various countries and consequently, on the specificity of Swiss psychiatry.

Firstly, there is the important role of psychoanalytically oriented psychotherapy in addition to psychoanalysis and other analytic approaches at the family, conjugal and group level. The only other example of psychotherapy assuming such large proportions is in the Cypres study [19], but this only covered psychiatrists working in the ambulatory sector and was extended to cover all forms of psychotherapy as opposed to solely the psychoanalytic form. The same applies to the findings of Yager et al. [2] for psychiatrists trained between 1956 and 1975 at UCLA's Neuropsychiatric Institute which showed 86% of them practising dynamic psychotherapy. Individual psychotherapy was only practised by 25% of Connecticut psychiatrists [14]. Only 35% of the Spanish psychiatrists working in the public sector made use of dynamic psychotherapy [11]. So far as members of the Texas Society of Psychiatric Physicians were concerned [12], only 39% carried out individual psychotherapy. And these authors also point to the change which came about in the Eighties when there was something of a switch towards brief and support therapies and away from longer, mainly psychoanalytically oriented therapies.

One might think that the psychoanalytic reference acquired this predominance at the expense of the biological-type therapies. But we found that the vast majority of Swiss psychiatrists also use these biological treatments (mixed treatments 91%; pharmacotherapy 68%). So far as pharmacotherapy in particular is concerned, comparable findings are recorded in the studies by Yager et al. [2], where it is used by 63% of psychiatrists, Kane and Harper [12], where 59% practise it, and Guimón et al. [5], where the figure is 84%. Olfson et al. [20] found that 62% of the members of the APA prescribed medication. These were mainly young psychiatrists whose patients included higher proportions of schizophrenic and other psychotic disorders.

Coexistence of therapies of different orientations and combined therapies

The two mainstays of Swiss psychiatry practice are treatments with a biological component and psychoanalytically inspired therapies. In their study of psychiatrists in university services in the United States Bodkin et al. [21] confirm that the distinction established by Hollingshead and Redlich [22] between biologically oriented and psychotherapy oriented psychiatrists is as real as ever it was. However their respective proportions have been reversed since the Seventies in favour of biological psychiatry. In Switzerland, moreover, these two orientations are not mutually exclusive. In fact nearly two thirds (60%) of the biological psychiatrists also do psychoanalytically inspired psychotherapy, but very few of them practise psychoanalysis (4%). And conversely although one encounters hardly any pharmacological treatments as such among the psychoanalyst psychiatrists, more than a third of them (37%) do resort to mixed treatments. We do not know whether they use medication in the actual context of their psychoanalytic practices or whether this is reserved for a section of their patients who are not undergoing analysis.

This trend towards using therapies combining psychodynamically or analytically inspired psychotherapy with the prescription of psychotropics was already being flagged up in 1978 by Redlich and Kelert [14] who showed that about 40% of the patients undergoing psychotherapy in Connecticut were also receiving medication, a combination which proved more effective and which, in their view, should be advanced as a supplementary model in psychiatric training. The work of Beitman and Maxim [3] on psychiatrists in Washington State was also undertaken in order to redefine the

training programme in accordance with future needs. They note that 38% of the patients treated by their respondents received combined therapies, mostly psychotherapy plus medication. Prescription of medication does not seem to distinguish the non-psychoanalyst psychiatrists from the psychoanalysts. Kane and Harper [12] in fact found no difference so far as the use of anxiolytics and antidepressants was concerned. Two thirds of psychoanalysts prescribed them for panic disorders, three quarters for major depressive episodes and a third for obsessive-compulsive disorders when these various disorders surfaced during analysis. Post [16] also instanced the advantages of combining medication with psychotherapy, principally for mood disorders.

According to Donovan and Roose [17] 18% of the patients in psychoanalysis with the training analysts of the Columbia Center for Psychoanalytic Training and Research had been prescribed psychotropics. Most of them were major depressions and dysthymias according to the DSM-III-R, with 91% receiving an anti-depressant treatment. The analysts estimated that not only was there an adequate therapeutic response to the psychopharmacological treatment but that this had also had a positive effect on the psychoanalytical process as such. This demonstrates that pharmacotherapy is no longer, in point of fact, judged to be incompatible with the principles of psychoanalysis. This trend is borne out by the finding that medication is used by the psychoanalytically oriented Swiss psychiatrists, either in conjunction with psychoanalysis or for a section of their patients. Heim [15] also stresses the importance of combined therapies, considering them an important challenge in the context of the confrontation between different theoretical models and above all in terms of their integration into a more synthesised approach. Whatever the argument, this integration is starting to happen in practice, with the various opposing movements no longer as polarised as they were in the past [21].

Diversification of activities and work settings

We have found that virtually all Swiss psychiatrists have clinical activities, three-quarters of these consisting of clinical work at the individual level. Two-thirds of the psychiatrists are engaged in training (teaching, supervision, consultancy or Balint groups), almost half provide expertise or take part in meetings.

Schaufelberger and Westkämpfer [23] have obtained similar results in a more limited study carried out in the Canton of Bern. It is also clear from other studies [2, 3] that psychiatrists' principal activity is direct contact with patients. The findings of the study by Guimón et al. [5] correspond quite closely to the data for Switzerland: 86% of all Spanish psychiatrists have a clinical activity.

But several studies also suggest that the work of today's psychiatrist is split into a greater number of activities carried out in a greater number of settings. This diversification clearly reflects the changes in practice modalities since, according to Fenton et al. [1] and Olfson et al. [20], it prevails as much among psychiatrists who have long since completed their training as among those who graduated more recently. For Dorwart et al. [6] this diversification is increasingly taking the form of sub-specialisation in psychiatry. We have no longitudinal data so far as Switzerland is concerned, but the results seem to indicate that the same thing is happening here too, since on average Swiss psychiatrists assume 3.4 different activities, a higher proportion than in the United States.

Switzerland, compared with other countries, seems to be characterised by a more clear-cut separation between public and private and a high frequency of exclusively private practice; 37% of psychiatrists are both in the private and public sector, 33% exclusively in the public and 30% exclusively in the private. According to the study by Yager et al. [2] three-quarters of the psychiatrists established in private practice regularly collaborate with the academic activities. And 59% of Spanish psychiatrists work both in the private and public sector, 37% exclusively in the public and only 4% exclusively in the private sector [5]. The structure of psychiatric practice in Australia is close to that of Switzerland since 32% of psychiatrists are in exclusively private practice [24].

Positions of therapeutic profiles in the Swiss psychiatric field

Typological analysis of the therapeutic practices shows five well-differentiated therapeutic profiles: biological, psychoanalytic, systemic, cognitive-behavioural and generalist. The results for psychiatrists' work settings and different activities according to their therapeutic profile can be interpreted as indices of the positions they occupy in the psychiatric field. Psychoanalyst psychiatrists and generalist psychiatrists usually work in private practice, whether exclusively or in conjunction with functions in the institutional sector, at a rate of 81% and 79% respectively. Representatives of these two

profiles also devote significantly more time to clinical activities, especially clinical work with individuals rather than with families, couples and groups. Bergeret et al. [25] confirm this predominance of private practice for psychoanalysts belonging to the Psychoanalytical Society of Paris, and also stress the fact that the majority (69%) of psychoanalytically inspired psychotherapies are on an individual basis. Brauer & Brauer [26] found the percentage of members of the American Psychoanalytical Association who worked in private practice (77%) closely approximated the figure for Swiss psychoanalyst psychiatrists.

Psychoanalysts are the most numerous of all the therapeutic profiles to act as facilitators and collaborators with institutions. In fact, 28% of the psychoanalysts have posts as services supervisors or consultants for a number of hours a week, and 23% work part-time as members of care teams. This position as theoretical and therapeutic guarantors for the principles of psychoanalysis probably constitutes the most sure means of perpetuating the pre-eminence of psychoanalytical practice, and of ensuring through theoretical and practical training the renewal of generations of psychoanalytically oriented psychiatrists [10]. This is all the more important in that they largely constitute the archetypal figure of the psychiatrist practising psychiatry not in an institution but in direct contact with the public.

In the United States this type of collaboration between private and public sectors corresponds to one of the two main forms of co-operation between the two [20]. The second is the biologically oriented psychiatrists who primarily take on treatment of the more severe pathologies – schizophrenia and affective disorders. The prescription of psychotropics is particularly high in these cases. But the dominant strategy of biologist psychiatrists in Switzerland is different. They are more strongly represented at the institutional, hospital and/or ambulatory level, and hold important posts in their hierarchies.

The systemicians have a more hybrid status compared with the strong positions occupied by the psychoanalysts and biologists. They have no solid institutional footing and are only over-represented at the ambulatory/outpatient level. They are not in a dominant position here. Although they also have office-based private practice, they exercise few functions which mediate between private and public sector and thus have much less access to the privileged roles of facilitators and guarantors in the training of young psychiatrists. Their only distinguishing feature seems to be that their major clinical activity is with families and couples.

No specific status for cognitive-behavioural and generalist psychiatrists in Swiss psychiatry was noted.

Different therapeutic profiles as well as their position in Swiss psychiatry are probably on a par with theoretical models of reference, the interests as well as the professional and ideological commitments of psychiatrists. These aspects, which are not taken into account in this analysis, could confirm our results.

Changes and probable evolution in the psychiatric field

Almost all studies dealing with the field of psychiatry stress a number of changes which have taken place. On the level of the orientation of practice, the increased importance of biological psychiatry, the rise of the systemic approach and the relativisation of the pre-eminence of the psychoanalytical model have been underlined. On the level of clinical activity, long-term treatments have been cut back, above all those inspired by psychoanalysis, in favour of, amongst others, shorter therapies and crisis intervention. Which factors have either encouraged or made necessary these changes are at the moment limited to conjecture. Those inside the field of psychiatry are the most frequently referred to: diversification of techniques following the restructuration of institutions, practice and care patterns of patients, limits to the efficacy of therapies, remedicalisation of psychiatry not only following biological advances, but also through modifications of the collaboration with physical medicine and by a greater accent placed on liaison psychiatry.

But it could be questioned whether external factors have not also conditioned this evolution, in particular the demands addressed to psychiatry. For, parallel to a medical recentering, psychiatry has seen its field of intervention considerably enlarged to domains concerning, for example, the victims of violence, psychological problems associated to the couple, family, and professional settings, immigration, precarity, problems linked to euthanasia, the mental health of prisoners, of the elderly and of single parent families. The modifications of psychiatric practices and their references can thus be understood as responses to new challenges made up of the new situations with which it is confronted. Consequently it could be considered as a process of adaptation to a modified reality for which new techniques and competencies had to be developed which turned out to be both more adequate and appropriate than the traditional therapeutic options. This evolution has been

made even more indispensable by the massive entry, into the market of care, of disciplines and professional competitors. These new offers, founded on confirmed competencies, or auto-proclaimed competencies, have been carefully fitted into – at least during a first period – those areas or niches which were not covered by psychiatry.

It is, finally, probable that other external factors will accelerate these changes or produce new ones capable of modifying, in their turn, the data of the psychiatric field. This is shown by the increase in demands for psychiatric care which has been observed over a recent period. It is undoubtedly related to the present economic crisis, but also to the context of insecurity and threat which this crisis has produced throughout the social system. However, this growth of need for psychiatric treatment takes place at the moment when an attempt is being made to limit the increase in costs of the health system, even to diminish medical consumption. The principal actors engaged in the health system (political authorities on Federal and Cantonal level, health insurance schemes, doctors and other health professionals) represent divergent interests and follow contradictory strategies. Some would advocate the recognition of psychotherapies practised by those other than doctors, to be covered by the same benefits from the sickness insurances, hoping to open up competition and diminish costs. Others, opposed to these measures, attempt to diminish costs by revising tariffs downwards, and above all by imposing strict limits to the number of acts taken into account for the reimbursement of benefits, even by influencing the types of treatment which should be recognised or not. This clearly shows a determination to influence indications, and this in the absence of univocal criteria of the comparative quality and efficacy of different therapies. However, the definition of therapeutic standards implies preliminary specialised research thanks to which criteria could be refined and operationalised.

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