

2001

A Phenomenological Analysis of The Psychotherapist's Experience Of Delivering Psychotherapy In A Managed Behavioral Health Care Environment

Jami M. Messina-Connolly
Seton Hall University

Follow this and additional works at: <https://scholarship.shu.edu/dissertations>



Part of the [Mental and Social Health Commons](#)

Recommended Citation

Messina-Connolly, Jami M., "A Phenomenological Analysis of The Psychotherapist's Experience Of Delivering Psychotherapy In A Managed Behavioral Health Care Environment" (2001). *Seton Hall University Dissertations and Theses (ETDs)*. 93.
<https://scholarship.shu.edu/dissertations/93>

**A Phenomenological Analysis of the Psychotherapist's
Experience of Delivering Psychotherapy
in a Managed Behavioral Health Care Environment**

By

Jami M. Messina-Connolly

Dissertation Committee

Shawn Utsey, Ph.D., Mentor

John Smith, Ed.D.

Andrea Notare, Ed.D.

**Submitted in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy**

2001

Dedication

I am unable to individually thank all of the people (friends, colleagues, participants) who took an active role in the completion of this project. I am grateful to all of you for your assistance and support. The following people were and are dearest to me.

For my mother, Joanne, who has spent my lifetime reminding me I can accomplish any goal to which I aspire. She remains my biggest fan and takes a level of pride in my accomplishments no other parent could. Her sacrifices for myself and my siblings, and her willingness to put herself second, never went or goes unnoticed.

For my father, Sebastian, who instilled in me an unabating thirst for knowledge, culture, and achievement; he continues to give his encouragement and support with every new goal I set. My parents became amazing temporary parents to my son and ran my home when this project prohibited me from doing so. I am blessed to have them.

For my son, Christian James, whose birth awakened in me feelings of love and inspiration I never imagined could be reached. My desire to be a positive role-model for him was, is, and always will be what motivates me through difficult times.

For my daughter, Samantha, it was the news of your impending arrival that made finishing this project enjoyable. My children are my reminder that completing this degree was unmistakably the one and only decision for me. I thank God for them every day.

Finally, and most importantly, for my husband Brian who made sacrifices most other spouses would not even consider by putting his career on hold and becoming a full-time parent to our children. He was my cheerleader and coach when quitting seemed inevitable, my sounding board when frustration prevailed, and my comfort when fear reigned. He has taught me the real meaning of the words patience, perseverance, love, and dedication simply through his encouragement and support of me. No person could have a better friend and companion. I am truly blessed to have him in my life.

God Bless America 9/11/01

TABLE OF CONTENTS

| | Page |
|--|------|
| Dedication_____ | 2 |
| TABLE OF CONTENTS_____ | 3 |
| CHAPTER I_____ | 6 |
| Abstract_____ | 6 |
| Introduction_____ | 8 |
| Introduction and Statement of the Problem_____ | 8 |
| Purpose of the Study_____ | 17 |
| Research Questions and Sub-Questions_____ | 20 |
| Definitions_____ | 20 |
| Limitations and Delimitations_____ | 22 |
| Significance of the Study_____ | 24 |
| CHAPTER II_____ | 26 |
| Literature Review_____ | 26 |
| Purpose of Literature Review in Qualitative Analysis_____ | 26 |
| Historical Background of Managed Health Care: | |
| Health Maintenance Organizations_____ | 27 |
| Historical Background of Managed Behavioral Health Care_____ | 33 |
| Public and Professional Opinions of Managed Care_____ | 39 |
| Managed Care Legislation_____ | 48 |
| Managed Care Litigation_____ | 51 |
| Managed Care Guidelines for Mental Health Treatments_____ | 55 |
| Psychotherapy Outcome Studies: The Effectiveness of Psychotherapy_____ | 59 |
| Characteristics of Effective psychotherapy: Common Factors_____ | 65 |
| Time-Limited vs. Time-Unlimited Therapy: Efficacy and Effectiveness_____ | 70 |
| Impact of Theoretical Orientation on Psychotherapy Outcome_____ | 73 |
| Empirically Validated and Supported Treatments: EVT and EST_____ | 81 |
| Standards of Care_____ | 86 |
| Proponents and Dissenters of EVT and EST_____ | 88 |
| Training in EVT and EST_____ | 91 |
| Examples of EVT and EST_____ | 95 |
| Outcome Measures_____ | 98 |
| Ethical Principles of Psychotherapy_____ | 112 |
| Recommendations_____ | 128 |

| | |
|--|-----|
| CHAPTER III | 138 |
| Procedure | 138 |
| Introduction | 138 |
| Assumptions and Rationale for a Qualitative Design | 138 |
| Phenomenological Philosophical Perspective and Approach | 139 |
| Qualitative Inquiry: Sampling Procedures | 142 |
| Setting | 143 |
| Entry, Access, Rapport, and Ethics Issues | 143 |
| Role of the Researcher | 145 |
| Data Collection Methods: Interviewing and Level of Data Collection | 146 |
| Data Analysis Procedures | 148 |
| Epoche or Bracketing | 151 |
| Significant Statements: Horizontalizing | 152 |
| Invariant Horizons: Meanings of Statements | 152 |
| Themes of Meanings | 153 |
| Textural Descriptions | 154 |
| Structural Descriptions: Imaginative Variation | 154 |
| Composite Textural Description: Exhaustive Description of Phenomenon | 155 |
| QSR N5: Computer Analysis Program | 156 |
| Methods for Verification: Criteria for Trustworthiness | 159 |
| Application of Qualitative Research Procedures in the Current Analysis | 161 |
| Choosing Qualitative Inquiry | 161 |
| Population, Participants, and Sampling Procedures | 163 |
| Table 1 | 164 |
| Setting | 165 |
| Entry, Access, and Rapport | 165 |
| Personal Biography and the Role of the Researcher | 167 |
| Data Recording Procedures | 169 |
| Data Collection Procedures | 171 |
| Data Management Procedures | 173 |
| Data Analysis Procedures | 176 |
| Epoche or Bracketing | 176 |
| Significant Statements: Horizontalizing | 176 |
| Invariant Horizons: Meanings of Statements | 178 |
| Themes of Meanings | 179 |
| Individual Textural and Structural Descriptions | 184 |
| Composite Textural Description: Exhaustive Description of Phenomenon | 185 |
| Member Checks | 185 |

| | |
|--|---------|
| CHAPTER IV | 187 |
| Findings and Presentation of Data | 187 |
| Participant's Account of the Experience | 187 |
| Table 2 | 187 |
| Therapist A: Textural and Structural Description | 189 |
| Therapist B: Textural and Structural Description | 197 |
| Therapist C: Textural and Structural Description | 206 |
| Therapist D: Textural and Structural Description | 216 |
| Therapist E: Textural and Structural Description | 228 |
| Therapist F: Textural and Structural Description | 238 |
| Composite Textural and Structural Descriptions | 247 |
| Theme 1: Managed Care Policies and Procedures: Impediments to Treatment | 247 |
| Theme 2: Monetary and Financial Problems with Managed Care | 254 |
| Theme 3: Changes in the Treatment Process and Components of Psychotherapy | 259 |
| Theme 4: Impact on the Person of the Therapist Working with Managed Care | 272 |
| Theme 5: Repercussions on Patients from Direct Involvement with Managed Care | 281 |
| Theme 6: Responses to Managed Care: Manipulate or Avoid the System | 293 |
| Theme 7: Changing the Health Care Insurance System | 302 |
| CHAPTER V | 313 |
| Summary, Implications, and Outcome | 313 |
| Distinguishing the Study from Prior Research | 313 |
| Study's Relation to Theory and Literature: Commonalities and Contrasts | 316 |
| Researcher's Account of the Experience | 324 |
| Future Research or Studies | 326 |
| Outcomes and Conclusions in Terms of Social and Professional Implications | 331 |
| References | 335 |
| Appendixes | 346 |
| Appendix A: Initial Telephone Introduction | 346 |
| Appendix B: Consent Form | 347 |
| Appendix C: Protocol Form | 349 |
| Appendix D: Follow-Up Letter to Participants | 351 |

CHAPTER I

Abstract

This qualitative analysis employed Moustakas' Transcendental Phenomenological Approach to develop an in-depth understanding of psychotherapist's experience of conducting psychotherapy within a managed behavioral health care environment. Researcher overwhelmingly suggests that psychotherapy is effective in assisting clients with psychological problems. However, a majority of psychotherapists espouse negative opinions of the effects of managed care for themselves and the clients they service.

Six psychotherapists, from the four primary disciplines licensed to provide psychotherapy, provided in-depth interviews about the impact of managed care on the process of delivering psychotherapy services. Interviews took place in the private offices of participants. Interviews were audio-recorded and ran an average of 90 minutes in length. Observation, field, and journal notes provided supplemental data. QSR-N5, the 5th version of NUD*IST, was the computer program employed during the data collection and analysis procedures. It is a program which assists with the structuring, organization, coding, and analysis of non-numerical, unstructured research data.

The findings from this analysis indicate that psychotherapists across disciplines experience managed behavioral health care as a detrimental interference into the therapy process. Participants focused on the amount of clinical time lost to care authorization procedures, reimbursement rates and personal income reductions, and quality of care issues for the clients they service. Specifically, participants believed that managed care involvement led to therapist distractibility, physical and emotional unavailability, and an

inability to develop the therapy relationship as a therapeutic tool; it also led to a decline in client's investment in the therapy process. Managed care dictated psychotherapy was viewed as a Band-Aid for client problems.

In response to the perceived negative repercussions of managed behavioral health care involvement in the therapy process, practitioners initially manipulated around managed care rules and regulations to obtain the approvals for treatment they believed were clinically indicated. When this approach proved too cumbersome, participants chose to abandon working with managed care systems, primarily by negotiating out-of-network fees with clients which enabled them to conduct therapy they believed was clinically indicated. Finally, participants believed that government regulation was necessary to contain the clinical and financial abuses of the managed care companies; they foresaw a future insurance system that included both managed care and traditional plan features. Implication for policy and practice are discussed.

Introduction

Introduction and Statement of the Problem

Comprehensive medical insurance became increasingly widespread following the close of World War II. It was a means of attracting prospective employees in lieu of wage and price controls. With post-World War II economic growth, development of labor unions, and technological medical advances, people increasingly came to view health insurance coverage as a right or entitlement (Anders, 1996). Health care was a booming industry with unlimited resources to fight disease; in turn, utilization rates increased along with service prices (Broskowski, 1991). Since the 1950's, many Americans receive health insurance as part of employer-funded worker's compensation packages (Frank and VandenBos, 1994). Though in 1940 only 10% of the population had health insurance; by the 1960's this number rose to 60%. The number of health insured Americans peaked at 188 million during the 1980's (Anders, 1996). As of 1998, 125 million Americans were covered by health insurance (Sleek, 1998, June).

The increases in health care costs over the last 50-60 years have been extensive. In 1940, health care accounted for 4% of the Gross National Product (GNP); since then, costs have risen more than 10% annually. When Medicare and Medicaid were enacted in 1965, health care expenditures accounted for 6% of the GNP (Anders, 1996). In 1981, health care accounted for 9.8% of the GNP; in 1987, it accounted for 11.1% of GNP and far exceeded the rate of inflation (Broskowski, 1991). Annual health care costs increased 39% in 1988. At the close of 1997, that number rose to 13.5% of the GNP or 367 billion dollars; the equivalent of 21.1% of total Federal Government expenditures (National

Center For Health Statistics, 1999). The Health Care Financing Administration predicts that health-care spending will increase to 2.1 trillion dollars by 2007, largely due to the aging of baby-boomers (Farberman, 1999, February).

The United States government, private employers, insurers and the general population have become extremely concerned about health care expenditures and the quality of that care. In an effort to address escalating medical costs, financial abuses in the health insurance industry, and the millions of Americans living without health coverage, President Richard Nixon introduced the Health Maintenance Organization Act (HMO Act) of 1973. With this law, traditional insurance plans, known as indemnity insurance, were increasingly replaced with managed care insurance packages; a massive federal grant and loan initiative was advanced to bolster the development of less expensive insurance plans that were expected to drive down costs through free-market economic laws (DeLeon, VandenBos, & Bulatao, 1991).

The HMO Act of 1973 was designed to build a health care system focused on wellness and prevention of disease. The act authorized over 375 million dollars in grants and loans, over a 5 year period, to encourage the formation and expansion of managed care insurance plans (Anders, 1996). For the first time, for-profit corporations could partake in the development of a managed care insurance company. Federal qualifications and standards were developed to which the managed care insurers were held accountable. To qualify, companies were required to provide coverage for eight basic areas: referral and consultation services, diagnostic laboratory services, emergency health care, diagnostic and therapeutic radiological services, home health services, preventive health

services, and outpatient mental health care, crisis intervention, and treatment and referral for alcoholism and substance abuse (DeLeon, et. al., 1991).

In the 1960's, 2% of the population received health insurance through a managed care plan (Anders, 1996); by 1983, the number rose to 5.1% (DeLeon et al, 1991). As of 1985, 10% of American's health insurance contracts were through managed care plans (Anders, 1996). With the support and initiative of President Jimmy Carter, between 1978-1988, the number of managed care companies reached an all time high of 707 operative plans (DeLeon, et. al., 1991). These numbers have since declined because many managed care companies have gone bankrupt or consolidated with other agencies.

The 13% of Americans enrolled in managed care plans in 1990 rose to 27% by 1997 (Farberman, 1999, February). In 1996, managed care had 58 million enrollees growing at a rate of 100,000 per week (Anders, 1996); by 1998, over 65 million people were enrolled in a managed care insurance plan (Kaiser Family Foundation, 1999, March). The changes within Medicare were comparable. In 1996, 4 million elderly belong to managed Medicare insurance programs with 20% annual increases in membership. By 1999, seven of the 39 million Medicare recipients received health insurance through managed plans (Kaiser Family Foundation, 1999, March).

Today, managed care health insurance is the dominant form of health care in America; 75%-80% of the insured population is contracted with some form of managed care (Kiesler, 2000; National Advisory Mental Health Council, 1998, May). This amounts to 161 million Americans (Fulton, 2000, June). Since the 27 years that modern managed care has existed, there have been many changes in the practices for all specialties and levels of medicine. Financially, this has meant closer monitoring of all aspects of health

care; unlike the post-WWII atmosphere of spending unlimited funds on health care procedures. Concern about the costs of health care will continue to rise as the largest cohort of American people, the baby-boomers, ages.

Understanding the impact of managed care on the field of psychotherapy is facilitated by exploring the historical background of insurance coverage within the mental health fields. Throughout the 1940's and 1950's, many insurance plans excluded mental health services as a covered benefit; in the 1960's, though some plans included mental health as a basic benefit, many offered it on an optional basis only (DeLeon et al., 1991). The HMO Act of 1973 required that mental health benefits be part of all federally-funded HMO plans, specifically with regard to emergency and outpatient crisis intervention and substance abuse care, in the form of 20 annual visits (Anders, 1996).

As managed care's cost saving ability was increasingly realized and as inpatient mental health care costs, accounting for the largest percentage of mental health spending since the close of World War II (Broskowski, 1991), began to exceed that of the medical specialties, more employers and individuals opted for managed mental health benefits (Pallak, 1995). Hitherto, indemnity insurance plans offered incentives for unnecessary hospital use by paying higher amounts for inpatient rather than outpatient care. In turn, utilization of private psychiatric hospitals increased and many general hospitals began to open psychiatric units because payments from Medicare were not restricted. According to Miller (1996), the number of private psychiatric hospitals increased from 180 to 250 between 1970 and 1985 and, between 1979-1988, admissions increased 247%. From 1959-79, national mental health care costs rose 12-20% annually (DeLeon et al, 1991).

By the late 1980's, mental health care costs were rising 12% annually and 10% of all health care premiums were being spent on mental health disorders (Anders, 1996). Correspondingly, enrollments in managed care companies for mental health benefits increased. In the 1960's, only 2% of the population belonged to a managed behavioral health care plan; by 1988, these plans covered well over 10% of the insured (Anders, 1996). In 1993, 80 million individuals received their mental health benefits through a managed plan; this number rose to over 100 million by 1995 (Humphreys, 1996). Kaiser Family Foundation (2000), notes that 88% of the 75% of Americans in managed behavioral health care plans have their mental health benefits contracted out to specified behavioral health managed care organizations (Kiesler, 2000); the equivalent of over 149 million Americans (National Advisory Mental Health Council, 1998, May).

During the 1970's and in response to the government's concerns regarding escalating costs for Medicare and Medicaid beneficiaries, the National Institute of Mental Health (NIMH), a division of the United States government, assumed greater responsibility as a third party mediator between mental health providers and consumers. According to Pallak (1995), the NIMH concerns resulted in a heightened need to produce replicable data concerning the efficacy or effectiveness of psychotherapy in terms of treatment outcome, design, length and delivery.

According to Packard (1995), the Boulder proclamation of 1947, in which the scientist-practitioner model was adopted within mental health research, was extended and altered. Psychotherapy research adopted the medical model clinical trial, akin to research conducted within the field of psychiatry and drug companies; a focus on internal validity, randomization, control groups, diagnostic nomenclature, and measurement of specific

changes and target problems. Goodman, Brown, and Deitz, (1992) write that decisions regarding mental health insurance reimbursement decisions are increasingly based on the goals of stabilization, elimination of symptoms, and quantification of issues. According to Goldfried and Wolfe (1998), these foci would help psychotherapy treatment research achieve scientific respectability and encourage continued grant appropriation to further mental health and psychotherapy research.

Within the mental health specialties, the debates with regard to the changes imposed by managed care are heated due to the subjective nature of the field. Possibly because of changes requiring psychotherapists to collaborate with insurance personnel for treatment authorization, many mental health practitioners have developed strong positive and negative opinions about the subject of managed care (Austad, 1998; Bilynsky, 1998; Chodoff, 1996; Cummings, 1998; Giles, 1998; Hoyt, 1996; Miller, 1996; Pipal, 1995, 1996; Sank, 1997; Sperry, 1998; Storch, 1996; Wylie, 1994). A report by the Kaiser Family Foundation (2000, February) suggests that negative professional and public opinion regarding managed care grows annually; 74% of Americans surveyed believe that problems with managed care are not improving and 58% of those polled expressed concern that their managed care companies would be more concerned about saving money than providing the best treatments, if they became ill.

The literature about managed mental health care is prolific with debates about the necessity and desirability of lengthy treatment, acceptability for and concern about brief, short-term, solution-focused, empirically-validated treatments, and psychotherapy outcome research with different theoretical orientations and treatment approaches (Lipchik, 1994; Vaillant, 1994; Walter and Peller, 1992). The salient issue centers around

what the goals of psychotherapeutic treatment are and/or should be. Eileen Sullivan, RN (personal communication, May 14, 1999), director of Utilization Review at St. Barnabas Medical Center, Livingston, New Jersey, observes managed behavioral health care companies appear to be concerned with symptom rectification and a return to baseline functioning for the individual(s) being treated at the inpatient level. There is a general trend away from long-term inpatient psychiatric hospitalizations, with their high costs, toward briefer, shorter-term treatments conducted at the outpatient level of care; there is also a growing emphasis on psycho-educational training and prevention of acute mental health deterioration. According to Martin Seligman (1995), some private practitioners seek to enhance personal growth, healthier coping skills, and functional improvement as well as symptom amelioration; helping distressed persons not only correct their acute dysfunction but learn to live more effectively, independently and productively.

Ethically, professional associations of all health care disciplines require their constituents to ensure the confidentiality, ongoing safety and well-being of those under their care (American Counseling Association, 1997; American Nurses Association, 1985; American Psychiatric Association, 1998; American Psychological Association, 1992; Dickson, 1995; Keith-Spiegel, 1985; Lakin, 1991; National Association of Social Workers, 1996). The issue of a psychotherapist's responsibility for client or patient well-being extends beyond the ethical into the legal realm. Though a managed care insurance company can deny treatment authorization and payment, the therapist remains responsible for ensuring their client's safety. Courts of law continue to hold the treating professional legally responsible for the client's or patient's well-being (Dickson, 1995).

Managed-care organizations are exempt from legal ramifications due to the Employee Retirement and Income Security Act (ERISA) exemption. ERISA is a 1974 federal law governing employee benefits which also has provisions exempting corporate employee benefits plans from state laws. Due to loopholes in this law, managed care companies have been able to have lawsuits against them for punitive damages dismissed (Anders, 1996). Negligence cases which have successfully been brought to fruition against managed-care organizations have come from federal employees or schoolteachers; individuals and insurance plans that are not covered by ERISA.

The significance of the legal aspect of the impact of managed care in general can be seen through its prevalence in the media and the present concern within the branches of government; for example, recent articles of Newsweek (Anonymous, Newsweek, July 5, 1999; Pederson, Newsweek, July 26, 1999) and proposed bills on the Senate floor (H.R. 1133; H.R. 1344; H.R. 2926; H.R. 3222; H.R. 4058) address the issues of patient protection from insurance underpayment and denial of care, the unionization of doctors to reestablish professional authority in medical decision-making, and the need to develop objective and uniform standards and definitions to guide insurance coverage decisions.

Though managed behavioral health care companies are stricter with decisions in the inpatient arena because of the high costs of such care, the professional behavior of outpatient practitioners has also been effected by the policies and procedures of managed care. The professional no longer makes unilateral decisions regarding patient care. Treatment plans often need to be authorized and justified. Theoretically-based treatment decisions for psychotherapeutic practice, developed through years of theorizing about human potential and psychopathology, are increasingly required to have an empirical

basis; the outpatient psychotherapist's professional judgment about clients needs to be grounded in facts. Some individuals in need of psychological help have had to terminate treatment without achieving either their own or the psychotherapist's treatment goals.

It is becoming increasingly difficult to treat clients for relatively long periods of time without restrictions on length, kind, and frequency of sessions. Advocates of the seriously mentally ill express strong concern about managed care's potential impact. Until recently, the various levels of government determined the kind and amount of funding to this group of clients, partially through Medicare and Medicaid. Coursey, Alford, and Safarjan (1997) expressed concern that congress and managed care organizations will undermine the services provided and destroy critical systems in intervention and support, thereby enhancing profits by constricting available services and sacrificing quality care for economic savings.

An examination of Freudian psychoanalytic theory, from which much of the practice of psychodynamic psychotherapy had been developed, illuminates the concerns of those trained in these orientations. Freud spoke about the conscious, subconscious and unconscious suggesting in his theory of personality that what is manifest or conscious is less significant for psychic functioning than that which lies below the surface, outside of the individual's awareness. With regard to treatment, Freud (1965) suggested that elimination of the manifest problem was a temporary solution to a problem whose root lie deep in the unconscious psyche; the catharsis and extensive examination of which must occur to provide lasting change. Though Freud's psychoanalysis was not always a long-term venture as popular opinion often has it, it could be a lengthy procedure because of the tendency of individuals to resist examination of painful material and change.

Little research, however, has been conducted on much of psychoanalytic theory, largely because the concepts elude operationalization; as such, its efficacy over a less lengthy, yet established treatment approach, cannot be determined. It is becoming more difficult to justify a lengthy treatment modality without supporting research by current standards to a managed behavioral health care insurance carrier whose goal is to optimize cost and quality. It has also been argued that one obstacle to the proposed treatment approaches and goals of managed behavioral health care is that all individuals cannot fit neatly into standardized diagnostic categories and resultant efficacious treatment, thus rendering standardized treatments, as defined by managed-care organizations, untenable.

Purpose of the Study

The present study was an extension of concerns voiced by psychotherapists in the literature regarding the impact that involvement with managed behavioral health care has had on the practice of psychotherapy. There is a paucity of empirical research regarding most components of these issues. Research into the effective components, processes and effectiveness of psychotherapy has not considered managed behavioral health care reimbursement as a variable to be addressed. Newer, more effective strategies for maximizing client change, within today's financial and time-constraints, cannot be developed without understanding the components of the therapy process that may have changed or need to be reassessed in an era of managed behavioral health care. Training, teaching, policy, and practice are all influenced by this information; an empirical understanding of these psychotherapeutic issues would be advantageous to these goals.

Phenomenological analysis was the inquiry approach most suited for this analysis because phenomenology “describes the meaning of the lived experiences for several individuals about a concept or phenomenon (Creswell, 1998). With it, one develops in-depth understandings of individual’s lived experiences. Phenomenological interviewing facilitated the goals of this study because it facilitates the descriptions and understandings of the meanings several individuals share about a phenomenon; lived meanings guide actions and interactions.

Phenomenology views human consciousness and experience as the proper subject matter for investigation; holistic perceptions of one’s immediate awareness and experience lead to an unfolding of phenomenal consciousness and cannot be doubted (Moustakas, 1994). Understanding depends on the interrelationship between conscious description and the underlying dynamics of experience which enable understanding the essence of the experience. Perceptions are the path or access to truth. This ontological view of reality necessitates focusing on the conscious experiences of individuals; reality is what people perceive it to be (Creswell, 1998).

The purpose of this phenomenological analysis was to explore and understand the experience of the process of psychotherapy, within involvement with managed behavioral health care from the perspective of individual licensed psychotherapists working in the private sector. The focus of the analysis was on the perceptions and experience of the psychotherapists. The goal of the analysis was a more thorough understanding and description of the essential meanings, themes, behaviors and experiences for practitioners conducting psychotherapy in private practice; a clearer understanding of the psychotherapist’s account of these experiences, responses and interpretations of events,

and how they have negotiated the sources of change within their professional roles. The relevant variables and issues regarding the impact of managed behavioral health care for psychotherapy had not been identified. This exploratory study could subsequently stimulate explanatory and predictive research of relevant psychotherapy variables.

The relevance of this exploration centered around the clients serviced by mental health practitioners. The findings and interpretations from this study can contribute to improving psychotherapeutic care. A thorough understanding of the implicit processes complex interactions, beliefs, and values are necessary to for improving practice. According to Moody (1999), due to the guidelines of managed behavioral health care, mental health professional organizations may need to more carefully attend to legal, ethical and practice guidelines and provide frameworks for the actual therapeutic process to more successfully proceed; enabling practitioners to optimally negotiate with managed behavioral health care organizations and provide the most effective psychotherapeutic help they believe is necessary to help people live fuller and more productive lives.

Empirical consensus about the experience of the impact of managed behavioral health care for the psychotherapeutic process is necessary, in light of existing literature about the components of effective treatment. This understanding can begin with rich descriptions of the complex circumstances experienced by psychotherapists; not yet available in the literature (Chodoff, 1996; Murphy, DeBernardo, and Shoemaker, 1998). When a greater understanding about these changes and relevant issues has occurred, practice and policy could be addressed to reflect them. This requires clearer details about the process, goals, and effectiveness of therapy within the guidelines of managed behavioral health care as the latter is the predominant form of health care insurance today.

It was the intent of this exploration to stimulate further research which would provide mental health practitioners with the empirical data to service clients more effectively through higher quality mental health treatments.

The mental health fields need to understand the consequences, and possible unanticipated outcomes, of this dominant form of health insurance for the actual practice and impact of psychotherapy. It was hoped that this research would help to define the important questions, variables, and challenges that could lead to more effective policy outcomes. The depth and richness of the qualitative interview inquiry approach offered much toward achieving a detailed explanation of these relevant psychotherapy processes (Marshall and Rossman, 1999).

Research Questions and Sub-questions

The following Grand Tour research question served as a guide for this qualitative study:

How has managed care impacted the psychotherapy you provide clients/patients?

Definitions

Because of the inductive and evolving nature of the qualitative research design, it was difficult to delineate definitions on an a priori basis, as is procedure for quantitative research (Cone & Foster, 1993); they were presented in text as they were addressed and discovered from participants in the investigation. The definitions which follow were designed only to provide a clearer level of understanding for the reader; no definitive conclusion about absolute definitions for concepts are made. Definitions are considered

tentative and, prior to conducting the study, are guidelines for entry into the field settings; they are offered as guidelines to delimit the study and are clarified by the participants throughout the study in the form of individual meanings and themes (Creswell, 1996).

Psychotherapy was prudently defined as an interpersonal process by which two or more individuals verbally and behaviorally communicate with the goal of assisting the client, the individual(s) who requests assistance, toward resolution of psychological, personal, interpersonal problems. Client was used synonymously with patient and refers to individuals, couples, families, and groups in mental health treatment. Psychotherapy was referred to without restrictions on theoretical orientation or chosen field of study or profession. A psychotherapist was defined as a professional trained and licensed in the delivery of mental health services, a state licensed professional in the mental health field, who works with individuals, families, couples or groups and who has been trained in psychotherapeutic techniques for working with clients in some form of psychological distress. A psychotherapist facilitates psychological and interpersonal changes requested by the client or deemed necessary and appropriate by the psychotherapist.

At this stage in the analysis, managed behavioral health care was defined as financial, reimbursement insurance plans for mental health services in which the provider of those services is required to receive authorization for initial care and ongoing treatment in order to receive financial numeration for those services. Though managed care plans vary in terms of level of insurance company participation in the therapy process, managed care here refers to all insurance plans in which treatment decisions are collaboratively made by insurance company personnel with the practicing therapist. Finally, mental health services delineates both psychological and psychiatric mental health issues as well

as substance abuse problems. Though obvious distinctions exist between the two categories of treatment, and treatments and problems within each category, references to mental health services are used as an umbrella term.

Limitations and Delimitations

External validity or generalization is limited in a qualitative study in the sense that the degree of generalization from one study is related to the degree of similarity it has with the participants, setting, methods, and contexts of another study (Kvale, 1996; Moustakas, 1994). As recommended by Marshall and Rossman (1999) no claims about extensive generalizations from this study were made from the findings and conclusions. These authors state that "the study is bounded and situated in a specific context" and influences "decisions about its usefulness for other settings" (p. 43). The limitations on reliability or replicability follow those limitations for external validity; a study using qualitative methodology is unique in that it occurs within a specific context, physically and temporally. The procedures for data collection and recording were hopefully detailed enough that another researcher wanting to replicate this study might find it easy to do so.

The findings from this study were limited to psychotherapists in private practice who have been practicing in the field for at least five years post-licensing. It is, again, only possible that the findings are transferable to those practitioners with related credentials, who practice in a similar setting, in the northeast part of the United States. The goal of such an analysis is to understand individual's meanings and experiential data as it occurs within a particular context and a particular point in time. As such, the data obtained during this analysis might not be found for psychotherapists in different parts of

the United States, working with different types of managed behavioral health care insurance plans and client/patients. The results of this study are bound by the training, personal experiences and orientations of the participants involved. The initial research question bounded or delimited the study without unduly containing it (Marshall & Rossman, 1999). The questions posed above focused this study onto the effects for psychotherapists, on the processes and perceived outcomes of practice in connection with managed behavioral health care.

The final limitation on this study concerns researcher bias. In qualitative inquiry, the person of the researcher is a primary tool in data collection and, often, analysis. The interpersonal nature of the inquiry process prohibits a stance of complete objectivity. As such, biases enter into the investigation. Through the Epoche process, those biases are delineated and suspended. This researcher entered this study with primarily negative opinions of and experiences with managed care; difficulties obtaining care approval, time spent on the telephone during the authorization process, and concerns about the privacy of client/patient information.

As this research progressed, however, the strong negative opinion moved very close to one of neutrality, though remaining a negative position. Specifically, the articles included in the literature review helped illuminate the positive aspects of managed care insurance with respect to staving off professional's abusive practices and constructively urging practitioner to better understand the application of therapeutic assessments and techniques as well as further developing maximally beneficial therapy approaches and tools. Managed care insurance does offer much toward positively enhancing the

psychotherapy fields. Psychotherapists could benefit from having open minds and adopting those into their therapy repertoires, as this researcher has done.

Significance of the Study

The impact of managed behavioral health care on the mental health field is much more clearly understood for inpatient rather than outpatient care; inpatient mental health care costs were spiraling upwards at rapid rates while hospitals and private psychiatric centers often exhausted the insurance premium dollars, and sometimes personal bank accounts, of individuals under their care. The trend in the mental health field is toward de-institutionalization of care in favor of outpatient, less restrictive treatments.

With the increased attractiveness of all levels of outpatient mental health care, it became necessary to develop a thorough understanding of how managed behavioral health care policies impact the direct provider of that care. Research needs to be significant, useful and relevant by contributing to theory, research and practice (Marshall & Rossman, 1999). There is, as yet, no empirically-based agreement about what the important issues and problems are for the outpatient client or psychotherapist, no thorough understanding of the psychotherapist's behavior with regard to managed behavioral health care insurance, and no professional consensus on potential or necessary systemic changes to optimize the quality and effectiveness of outpatient psychotherapy; no collective understanding has yet been gathered about the professional concerns and ideas of psychotherapists who must today work within managed-care guidelines.

Until the concerns of and effects for the psychotherapist, the direct and front-line provider of care, are explored and understood in detail, it would be difficult to validly

explore policy or procedural changes on the professional, organizational, or government level which, ultimately, will enhance the level of services received by those clients serviced by psychotherapists. Individual dissent, regarding the constraints of managed behavioral health care, is abundant. The literature regarding therapist variables with respect to the process of psychotherapy in general is also abundant. Presently, how the process of psychotherapy has or has not been affected by the presence of managed behavioral health care has not been understood or explained.

What is now needed is a more in-depth, consensual understanding of these issues so that a medium can be developed whose primary goal is quality care for those whom we service; more specifically, it is pressing that, as a whole, the mental health disciplines agree upon and empirically validate the pertinent psychotherapeutic issues as they relate to the healing of clients and the procedures and goals of treatment. Without achieving this consensus, government agencies, with the power to effect change, would be hard pressed to challenge the existing procedures of psychotherapists and managed care companies. This research was, therefore, pertinent to scientific, ethical, practice, and human interests.

CHAPTER II

Literature Review

Purpose of Literature Review in Qualitative Analysis

According to Marshall and Rossman (1999), the function of the literature is fourfold. First, it demonstrates the underlying assumptions behind the research questions. Second, the researcher's knowledge about the topic should be conveyed, within the intellectual background that supports the study. Third, it embeds the research questions within larger empirical traditions. Fourth, it should identify gaps in the knowledge base or previous research that the proposed study will attempt to fill; it identifies an area of knowledge upon which the study will expand.

The review may demonstrate areas that have not been adequately explored, particularly for processes not yet identified, only hypothesized, or not encompassed in theory. As such, the review should provide conceptual relatedness among the areas explored, forging links among disparate literature. As Marshall & Rossman (1999) note, "When research questions explore new territory, previous literature and theory may be inadequate for constructing frameworks for the study...previous research failed to conceptualize the problem in terms of process" (p. 46). These authors suggest that exploratory studies often include several bodies of literature because it is difficult to predict with literature will be most relevant as the analysis unfolds.

Moustakas (1994) reviews four major kinds of literature reviews, two of which guided the literature review in this study. First, an integrative review presents the state of the knowledge relevant to a topic and draws conclusions from the separate studies that are

included. Second, a thematic review presents the core themes found in related studies and reviews; findings are discussed with reference to the core themes through formal and informal methods. Informal sources include review papers, contacts with experts, government documents, and literature that comments on the topic (Moustakas, 1994).

The impact of managed behavioral health care on the process of psychotherapy is not one which has a specific, empirical, well-explicated literature or data base from which to draw, in spite of the fact that managed care has been addressed extensively in the literature in the form of personal opinion, legal concerns, and proposed negative outcomes for clients whose therapy was derailed by an insurance carrier denial of benefit authorization. The questions raised by existing literature are many but the knowledge has not been connected together. There has been very little empirical examination of the impact of managed care for mental health in general or psychotherapy in particular.

The following literature review is broad and encompassed a number of areas and issues related to managed care and psychotherapy. The goal of this literature review was to present as many of the pertinent issues as possible, thereby anticipating as many of the themes that participants in this study might touch upon through detailing their experiences. It was hoped that the participants in this study would lead toward which issues are communally relevant, thereby integrating the existing literature and adding to the present knowledge base.

Historical Background of Managed Health Care: Health Maintenance Organizations

Managed care insurance had its inception long before the HMO Act of 1973. DeLeon et al. (1991) note that, in the 1906 Northwest, a fee-for-service clinic practice

was established where two physicians provided a set package of health care to employees for 50 cents per individual per month. This rate-setting method would come to be known as capitation: a flat monthly rate, paid for the medical needs of each patient serviced. Anders (1996) notes that, in depression-era 1929 Los Angeles and Oklahoma, the first prepaid group practice emerged providing comprehensive health care packages, to counteract wage controls, at affordable premiums to local workers who could otherwise not afford medical interventions.

Henry J. Kaiser, builder of the Hoover Dam, developed a similar medical insurance contract with Dr. Sidney Garfield, as an incentive to attract workers to the remote building site. The coverage cost 5 cents per family per employee work hour. Later renamed Kaiser Permanente Health Plan, the company built its own hospitals and clinics, employing thousands of doctors to keep costs to a minimum. This staff-model or group-model HMO delivered care at clinics owned by the company, staffed by their full-time doctors and personnel (Anders, 1996).

President Truman attempted to initiate a national health insurance plan but had his idea defeated by the American public who rejected government interventions or programs affecting their personal lives. However, people wanted medical coverage for the new technologically-advanced procedures that would improve their quality of life. Indemnity insurance was developed to fulfill these needs. Under these plans, individuals had freedom to choose among health-care providers, sometimes with annual or lifetime capitation and at other times without. As technology advanced hospitals grew into multi-faceted medical centers, some doctors began to over-treat patients, with insurance companies absorbing the costs advanced medical testing equipment. Health-care costs

continued to rise; with ample financial resources, insurance companies paid out claims for most medical procedures without careful scrutiny about medical cost, necessity, or desirability (Anders, 1996).

The Nixon administration was the first to seriously scrutinize the emerging fiscal healthcare crisis and the numbers of uninsured workers. In 1971, Nixon brought the concept of managed health care and managed mental health care into health policy with the formal birth of for-profit managed health-care or HMO's. According to Frank and VandenBos, 1994, the goal was legislation for a national insurance system that would mandate all employers to pay a portion of a comprehensive benefits package for all employees. Congress passed the HMO Act of 1973 which required companies with more than 25 employees and a conventional health insurance plan to offer at least one HMO as an alternative for of medical insurance (Anders, 1996).

DeLeon et. al. (1991) note that amendments to the HMO Act liberalized requirements to make HMO's more competitive with traditional insurance programs and reduce the nation's annual health care expenditures. In 1976, HMO's were newly allowed to contract with individual practitioners or groups and other health care personnel, including nurse practitioners and psychologists, that did not meet the definition requirement of medical groups or Individual Practice Associations (IPA). In 1978, almost 100 million dollars was allotted to establish National Health Maintenance Organization Intern Programs to train individuals to become administrators and medical directors in HMO's. Additionally, HMO's were now required to disclose their financial information to monitor the profiteering and financial abuses found to be occurring in HMO's during

the 1970's. A 1986 amendment explicitly recognized psychologists for the first time among authorized health care providers (DeLeon, et. al., 1991).

The 1980's saw a continuation of double-digit annual increases in health care spending. Computer software developments allowed companies to track spending and medical excess in detail for the first time. Employers decided to have employees pick up a portion of medical costs in the form of copayments and deductibles. Unions, against having employees absorb the costs of care, opted for HMO or managed care coverage instead, where any amounts paid directly by the consumer would be less. Enrollment in managed care plans began to grow at exponential rates.

According to DeLeon et al. (1991), government support of HMO's was revealed with the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 in which managed care companies and states received increased payments for having individuals enroll in managed care plans, as well as Medicare recipients paying lower premiums for doing so. Additional government support of the managed care movement came from the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) that services over 2 million active duty personnel and over 7 million dependents and retirees. The CHAMPUS Reform Initiative offered the new HMO contract to the company who could keep costs and annual increases below those already achieved.

Health care again became a political focus during the 1992 presidential campaign due to continued annual increases in health care spending that well exceeded the rate of inflation and the large numbers of Americans, 20%, without health insurance coverage. Individuals without health insurance are more likely than those insured to receive inadequate health care and have more adverse health outcomes. Health care costs grew

11.4% in 1991. Though a portion of that increase reflects technological advances and greater complexity of services, the concern led to the development of the White House Task Force on Health Care (Frank and VandenBos, 1994).

According to the Kaiser Family Foundation (1999, March), employers became impressed by the cost savings of managed care; mainstream insurers like Cigna, Blue Cross and Blue Shield, Prudential, Aetna, began to buy into managed care organizations, impressed by their capacity to make money. There are a number of types of managed care plans, varying in degree of flexibility, cost-sharing, and utilization review standards. From least to most restrictive, these are fee-for-service with utilization review, preferred provider organizations (PPO), point-of-service plans (POS), and HMOs. Most HMOs require patients to see a pre-selected group of doctors or hospitals, authorization to see a specialist, be hospitalized or have extensive testing. Therapists, specialists, doctors, etc. attain membership in HMO's by application to provider panels. Partly in response to public concerns about restrictions to services and specialists, PPO have contracts between insurers and providers with the former receiving a discount on the latter's service rates with the guarantee of a number of referrals. Members are encouraged to use a preselected group of physicians and hospitals, weren't subject to as much advanced approval, could go outside the network if they paid a copayment.

A distinction needs to be made between controlling rates of use and costs. The primary mechanisms used to control utilization rates include treatment authorization, utilization review, financial incentives or restraints to receive care from certain providers, and requirements for employee cost-sharing. Primary mechanisms of controlling costs

include capitated or fee-for-service payments to providers, claims review, and extending coverage for less expensive, equally effective treatment alternatives (Broskowski, 1991).

Different managed care organizations spread costs between the employee or patient, provider, employers, and their own organization in different ways. Often, the provider accepts a prepaid rate to provide all care or sees patients at a discounted rate, in return for receiving more referrals. Called capitation, for each member served, a flat monthly rate is allotted. Employers and insurance agencies began to look closely at the costs of new testing, surgical procedures and chronic medical conditions, developing capitation levels for each based on medical and empirical data. Employers share the financial risk with a capitation payment: a fixed amount charged or spent on each member per month. According to Miller (1996), capitated contracts can be advantageous to the managed care company because the risk and cost is shifted to the provider; the provider can receive a bonus at year end if a savings is accumulated on the flat rates per patient paid, sometimes providing a financial incentive to under-treat.

The managed care company retains a portion of the money for administrative dues and uses the remaining funds to pay contractors to provide services. Clay (1998, August) notes that, as purchasers fight premium increases and managed care companies seek ways to lower their costs, cost-saving measures are directed at providers who often take percentage cuts in reimbursement rates. The contracts provide a financial incentive to direct treatment decisions by restricting or limiting services (Anonymous, 1998, November). Profits are calculated with a medical-loss ratio; the percentage of premium dollars used to pay out patients' medical claims. Money remaining from premiums is

considered profit (Anders, 1996). Though some patients exceed their monthly monetary allowance, the goal is to keep spending below total capitation rates and maximize profits.

By 1986, the majority of managed care companies were for-profit conglomerate agencies; competition among individual companies had increased to the point that mergers and acquisitions were common (DeLeon, et. al., 1991). In the late 1960's and 1970's, the majority of managed care companies remained non-profit organizations, using over 90% of premium dollars on patient care (Karon, 1995). By 1990, one third of managed care organizations were for-profit and began spending fewer dollars on direct patient dollars. Monies for direct patient care decreased to 78% of premium dollars in 1993 and, approximately 68-75% in 1994. Kaiser Family Foundation (1999, March) found over half of existing managed care companies were for-profit in 1996; currently over 63% of managed care organizations are for-profit, with stock valuing 39 billion.

Profiteering would begin a long list of concerns about managed care and lead to further amendments of the HMO Act of 1973. The concern that managed care companies were providing financial incentives to providers to limit care was addressed by the Omnibus Budget Reconciliation Act of 1986, making managed care organizations subject to civil penalties if such behavior was revealed (DeLeon, et. al., 1991). One goal for many for-profit managed care organizations is cost-containment and asset growth.

Historical Background of Managed Behavioral Health Care

According to Humphreys (1996), for many years psychotherapy was the providence of psychiatry. The first psychological clinic was founded in 1896, with psychologists assisting psychiatrists. With the increased need for psychological

interventions to treat military personnel during and after WWII, the Veteran's Administration established the doctorate as the entry degree for clinical psychologists, with salaries paid accordingly to this higher-level degree (Humphreys, 1996). The National Mental Health Act of 1946 established resources from federal programs, increasing the status and influence of psychology and other mental health disciplines, establishing them as viable professions to delivery treatments (Humphreys, 1996).

The mental health disciplines proliferated between the 1970's and 1990's: approximately 116,000 psychologists, counselors and social workers completed training in their respective fields (Humphreys, 1996). Concurrently, both utilization rates and costs of mental health services increased. In the late 1980's-90, mental health care costs were rising 12% per year, with 10% of health care premiums were spent on mental illness (Anders, 1996). According to Broskowski (1991), a percentage of the increase in utilization was due to the fact that some mental illness went unrecognized and untreated in previous decades, there was a decrease in stigma associated with psychiatric disorders, there were growing alcohol and drug problems and available treatment centers, and personal growth forms of psychotherapy became popular after the 1960's. Those afflicted with mental health issues were thus encouraged to seek out treatment and have it processed through insurance plans rather than paying out of pocket (Broskowski, 1991).

Managed behavioral health care insurance plans began seriously overseeing mental health benefits in the 1980's, due to the alarming rates at which costs were escalating, particularly in the inpatient care sector (Humphreys, 1996). Since the end of WWII, hospital-based, or inpatient care, not outpatient mental health services, has been the dominant contributor to rising costs (Broskowski, 1991). Almost immediately,

concerns arose that managed care could not work well in the less objective mental health specialties (Anders, 1996).

According to Broskowski (1991), insurance companies historically absorbed the increased health care costs, often associated with hospital charges, or passed them on to employers through higher premiums; employers, in turn, were given tax-breaks as an incentive to provide increasingly generous benefit plans. Hospitals and providers had little incentive to operate efficiently or cost-competitively (Broskowski, 1991). Indemnity plans, devoid of realistic financial ceilings, allowed psychiatric hospitals undue leeway in treatment; individuals were treated for as long as their health care coverage continued to provide benefits, though treatment may have been unwarranted or unhelpful. The practices of some professionals and mental health organizations bordered on fraud; there was incentive to find problems and over-treat (Anders, 1996). According to Kiesler (2000), under the typical fee-for-service system, there is no incentive for cost-effective care: the longer the treatment, regardless of outcome, the more lucrative for the provider.

Managed care is efficient with routine medical care, preventive medicine, and removing financial incentives to over-treat. Managed care reduces the amount of inappropriate care delivered and reduces fraudulent and abusive practices among providers (Broskowski, 1991). The system's vulnerability is the unexpected case which deviates from norms (Anders, 1996). Frasier (1996) noted that the prepayment system of managed behavioral health care establishes a financial incentive to under-treat the client or patient. When clinical decision-making is good, these changes function to a patient's benefit; with proper flexibility, managed behavioral health care case managers can extend

the range of treatments available to patients by authorizing innovative substitutes that are normally unavailable under traditional plan (Broskowski, 1991).

Managed behavioral health care, and their carve-out, companies were eager to end the spending excesses of the 1980's. This meant careful scrutiny of and authorization of treatment. A carve-out company is a company that take a specialized piece of the health-care market from the primary insurer and managed it (Anders, 1996). The specialties of mental health and substance abuse services are frequent foci of cost-cutting by managed-care plans; many plans have cut overall spending in half and yearly premium expenditures to 3% of total annual health benefits, saving their clients 1 billion dollars yearly. Managed behavioral health care insurers have been able to decrease mental health spending from 17% to 4.5% (DeLeon et al, 1991).

Frasier (1996) observed that Kaiser Permanente Health Plan, a forerunner of managed behavioral health care insurance discovered the value of mental health services for preventing over-utilization of facilities by healthy persons with somatic complaints. According to DeLeon et al. (1991), between 1959 and 1979, Kaiser Permanente Health Plan's mental health costs increased 3.5% annually while the national increases were between 12-20%. Called the medical offset effect, the term refers to reductions in cost and use of general medical services following psychological intervention, the savings of which more than pays for the cost of the psychological services (Frasier, 1996).

According to Karon (1995), a thorough discussion of the cost of psychotherapy must consider the decrease in other medical costs that accompanies mental health treatment. Karon (1995) adds that it has been established that psychological and substance abuse services reduce absenteeism from work, decrease the effects of stress-

related behavior on physical and emotional health, and decrease the use of intrusive and expensive hospital services (Frasier, 1996). The medical offset effect has been a selling point for many managed behavioral health care companies; it has also become a selling point for psychotherapists trying to market their services to employers and insurers.

The National Advisory Mental Health Council (1998) discuss a 1998 study of the effects on quality of care of financial incentives to limit access to that care. Results showed that limiting mental health services results in more disability claims being filed. For employers, the National Advisory Mental Health Council (1998) concludes that the savings generated by purchasing less expensive benefits packages may result in more spending on occupational disability claims.

Initially, cost-containment focused on reducing long hospital stays and diverting patients from inpatient care to a less restrictive outpatient therapy environment, including partial hospitalization programs and outpatient clinics (Broskowski, 1991). Attention was then directed to reducing outpatient mental health care costs. Karon (1995) observed that, though many managed behavioral care contracts allow for 20 psychotherapy sessions per year, there is often a push to terminate treatment much earlier. There is pressure to provide fewer than 10 sessions, though it is unclear what empirical standards are used to arrive at this optimal number. United Behavioral Services (UBS) of Rhode Island officially offered 20 session per year. Yet, case managers suggested that patients did not benefit from more than 6-8 sessions; 7.2 session was the average approved number of sessions. Therapists who confronted UBS worried about blacklisting, as psychotherapists who kept session number low were given more referrals (Karon, 1995).

Treatment authorization needs to be based on cost-containment and patient well-being. Karon (1995) notes that the German health care distinguishes between short-term (up to 60 sessions) and long-term (160-300) therapy. A neutral third-party therapist makes a collaborative clinical decision with the client's therapist about number of sessions required. Though long-term therapy is possible, Germany spends only 3% of total health care costs on psychotherapy. Karon (1995) suggests that a focus on long-term outcome along with cost-savings is what enables Germany to contain costs.

One would expect the number of outpatient sessions to increase as inpatient admissions decreased but this is not always the case. Bilynsky and Vernaglia (1998) contend that managed care reduces costs by limiting the number of therapy sessions available to each client: "...a fundamental ethical dilemma arises and quality of care decreases when the managed care system attempts to limit services (p.55)... "there is often a desire to find clinicians who have less expensive fees...most managed-care systems rely heavily on psychiatric social workers to provide treatment" (p.65). Managed behavioral health care companies often utilize masters-level therapists to save money (Broskowski, (1991). Today there is concern that doctoral-level psychotherapists will be replaced by masters-level clinicians, counselors and assistants whose fees are less.

Karon (1995) notes that obtaining authorization for psychotherapy within managed care can be a long process. Some psychotherapists and clients opt to bypass the system because of delays in receiving appointments, concerns about confidentiality, and difficulty attaining authorization to enter treatment with psychotherapists of their choice. From the standpoint of managed care, clients who pay out of pocket are financial successes (Karon, 1995). To assure authorization, some mental health professionals

describe patients' symptoms as more severe than they are, having learned what phrases will lead a managed mental health care company to authorize treatment. Some managed behavioral health care service hotlines are staffed with, and decisions made by, bachelor- and masters-level professionals, with limited clinical experience who have no live interaction with patients (Anders, 1996). Clinical care decisions are often made from these telephone contact calls. Anders (1996) notes, "A quick phone conversation can't accurately gauge how badly off such patients may be" (p.163).

Clay (1998, August) expressed concern that over-management of mental health would curtail the development of clinical improvements in treatment. He discussed psychotherapists' concerns that inappropriate cost-containment mechanisms would result in benefit restrictions and unilateral reductions in fees; potentially, as reimbursements continued to drop, the quality of care and quality of people entering the field would decrease as well. Mental health providers began issuing complaints about denials of appropriate care (DeLeon et al., 1991). Patients and families became concerned about the quality of care they were receiving. In time, public and professional concerns would be expressed more vocally. Regardless of one's opinion, managed care insurance appears to be an established part of the United States health care system, though its form may change as new data becomes available or public opinion and policy changes take place.

Public and Professional Opinions of Managed Care

Professional and public attitudes regarding managed behavioral health care remain conflicted. Media have contributed to negative images of managed care by publicizing poor outcomes due to insurance procedure, on television shows, television news stories,

books, and magazines (Anastas, 1999, August; Anders, 1996; Pederson, 1999, July). Publications abound aimed at explaining and instructing how to navigate and succeed in managed care systems, offering advice on choosing health plans, filing claims, and enhancing chances for obtaining authorizations (Castle Connolly Medical Advisory Board, 1997; Goodman, Brown, and Deitz, 1992). The APA Monitor (Sleek, 1999, February) reported the case of a Maryland teen, diagnosed with bipolar disorder and having made a suicide attempt at age 11, who was making therapeutic gains until the family's managed behavioral health care insurer canceled their contract with the boy's psychiatrist, reportedly forcing a delay in treatment and emotional setback for the teen.

Goldstein (1999, October) reports that over half of all Americans believe that managed behavioral health care companies fail to treat consumers well. Farberman (1999, February) summarized a 1999 Kaiser Family Foundation and Harvard University poll in which 86% of Americans favor government regulation and reform of managed care, though support decreased to 40% if legislation meant increased health-care premiums. The two greatest concerns expressed in this survey were the decreased amount of time providers spent with patients and difficulty seeing a specialist. Sleek (1998, June) cites a 1998 APA sponsored poll, conducted by Penn, Schoen & Berland Associates, Inc., in which two-thirds of Americans expressed a willingness to pay an extra 10 dollars monthly for insurance for expanding available care (Sleek, 1998, June).

Kaiser Family Foundation (2000, February), a leading researcher of managed behavioral health care, summarized their public opinion surveys from late 1997 to 2000. Seventy-four percent of Americans believe problems with managed care have not gotten better. At least 50% of those surveyed believe managed care has decreased time spent

with doctors, has made it harder to see specialists, and has decreased the quality of health care for the sick. In April 1999, 58% of Americans were worried that their managed care plan was more concerned with cost savings than with providing the best treatments.

As of August 1998, 36% had problems receiving information from their health plans, 26% had difficulty seeing a specialist, and 22% have wanted to file an appeals claims for denials. In February 2000, 66% wanted to sue their managed care insurer and 80% favored congressional action for comprehensive consumer. A follow-up Kaiser Family Foundation (2000, June) national survey found that the most common problems continued to be delays or denials of care, difficulty seeing a physician, and billing and payment problems. Twenty percent of those surveyed reported lost time from work, school or major life activities associated with these problems. Eighty-seven percent felt it would be helpful to appeal to an independent medical expert to resolve care disputes.

Some authors have chosen to highlight the shortcomings of managed care insurance. Miller (1996) asserts that managed care only redirects profits toward the insurer. He calls this "skimming off the top;" by setting capitation limits on allotted money toward length of hospital stays and number of therapy sessions, managed behavioral health care insurers attempt to keep treatment below calculated maximum expenditures, creating financial excess that the insurance company retains. Anders (1996) said surviving in managed care is achieved by denying or limiting care, redirecting profits from medical personnel to the people who run managed care companies and adds, "They have pampered themselves with corporate jets, sleek black limousines and private chauffeurs. They have bought yachts, vacation homes, unwittingly emulating the stereotypical 'greedy doctors' that managed care was supposed to flush away" (p.57).

Anders (1996) believes managed care administrators, often not involved with patient care, are buffered from patients' individuality and needs and thus unable to consider the human dimensions of their work. Anders (1996) views health care as intensely personal; a service delivered one patient at a time. The system, in turn, urges professionals to think like economists, pulling back from individual cases and focusing more on the allocation of resources. Anders (1996) notes, "Physicians will be forced to choose between the best interests of their patients and their own economic survival" (p.79); a conflict of interest where providers are forced to choose between obligations to patients and a loyalty to the managed care companies that pay their bills.

According to the National Advisory Mental Health Council (1998), three issues form primary areas of concern for professionals: access, quality and consumer-provider awareness. Access is the ability to obtain treatment with appropriate professionals for mental health and substance disorders; it includes waiting time for appointments, telephone access, availability of service continuum, a sufficiently wide range of providers from which to choose, geographical access, and cultural competence in providers. Managed behavioral health care authorizations are determined by a number of factors: clinical status of the client, generosity of the benefit plan, authorization guidelines, the provider's clinical reporting skills, and the managed care case worker's clinical skills. Financial incentives to deny care confound proper authorization for it.

Currently, there are no uniform standards or criteria for defining or tracking access to mental health services. Baseline criteria from actuarial studies, predating managed behavioral health care, provide incomparable data; wide variability exists in statistics regarding access, ranging from 0.9% to 9.7% for use of outpatient mental health services,

suggesting some companies have strict criteria for access to care. Consistently, outpatient visits increase after managed care is introduced into insurance plans (National Advisory Mental Health Council, 1998). A Pricewaterhouse-Coopers analysis for the APA Practice Directorate determined that HMO's could generate 280 million dollars annually if as few as one percent of claims are denied (Rabasca, 1999, November).

Delivery of mental health services can be delayed due to the physician gate-keeping process. DeLeon et al. (1991) cite a 1987 Rand Health Insurance Study in which depression was more likely to be detected by a mental health specialist than a medical clinician, and, among medical personnel, less likely to be detected in HMO managed care plans than fee-for-service plans; depressed patients in fee-for-service plans fared better than those in managed care plans. Citing two studies comparing fee-for-service and managed care plans, Ivan Miller (1996) concluded that patients in managed behavioral health care plans fared worse, more frequently deteriorating in level of functioning, than in traditional plans. Additionally, about 50% of clinically depressed patients were improperly diagnosed by managed care general practitioners and than by psychiatrists.

According to Farnerman (1999, February), professionals are concerned with delays in scheduling appointments and with the time-consuming nature of applying for care authorizations. Concerns about financial incentives to limit referrals to specialists were addressed by the Omnibus Budget Reconciliation Act of 1986; managed care or competitive medical plans are subject to civil penalties for payments to physicians to limit or reduce services to Medicare beneficiaries (DeLeon, et. al., 1991). According to Rabasca (1999, February), managed care organization can create additional barriers to

obtaining mental health treatment as patients can be reluctant to disclose information about sensitive issues before they authorize treatment.

Quality of care, the second area of concern, is possibly the overriding issue for providers and recipients of mental health services. Quality of care assesses the structure of the health care system, the process of the delivery of services, and the outcomes for the consumer such as clinical and functional outcome and consumer satisfaction (National Mental Health Advisory, 1998). Within the current systems, systematic empirical assessment and evaluation of quality of care, treatment guidelines, and treatment outcome, is limited. The National Advisory Mental Health Council (1998) cites two recent attempts within the managed care industry to create universal measures of quality: HEDIS 3.0, a set of 75 performance measures of access, process and patient satisfaction and PERMS 2.0, consisting of measures specifically adapted to mental health issues, that is pending development and is not available for use.

Managed behavioral health care succeeds in curtailing rising mental health care costs but has lagged behind with measuring quality of care, a variable often neglected by managed care organizations. According to Broskowski (1991), the relationship between cost and quality suggests that poor quality of care often leads to additional care for the same problems, at more cost. Kiesler (2000) reiterates this concern stating, "Under managed care, the cost is considerable when a patient comes back into the system for a second treatment of the same problem... Taking care of patients' problems sufficiently so that the patients do not return to the system becomes very important" (p.485).

In a study of 13 managed behavioral health companies, the National Advisory Mental Health Council (1998) found that hospital readmission rates ranged from 2%-41%

and providing outpatient follow-up to hospitalization within 30 days of discharge 39%-92% of the time. The council concluded that "Managed behavioral health care companies were more consistent in their capacity to limit treatment..." (p.27). The council stated that long-term assessment of outcomes, rather than short-term cost savings, is needed to provide a clearer picture of outcome.

Karon (1995) notes that long-term prevention, as a means of cost containment, is neglected when a company focuses on profitability and cost containment. Because managed behavioral health care organizations cannot be assured that covered patients will remain with their plan the following year; their focus turns to cost-savings in the current fiscal year, less investment on prevention with high-risk patients, cutting actual services, and utilizing less expensive personnel. Concern about high risk patients and the seriously mentally ill is a relevant issue for mental health practitioners. With capitation, profit for providers to treat these populations is lacking, fostering reluctance to treat them (Karon, 1995). The American Psychological Association (APA) suggests that managed care's most dramatic abuses occur in the mental health areas because, concerned about stigma, clients are less likely to advocate for their rights (Rabasca, 1999, February).

Ivan Miller (1996), asserts that managed behavioral health care is detrimental to the practice of outpatient psychotherapy because under-treatment lowers service to levels insufficient for effective care and denies necessary longer-term treatment to individuals with moderate to severe problems. Over 50% of psychologists surveyed indicated that treatment was discontinued by the insurance company when it was still indicated or was denied by rigid criteria that did not consider the specific case. Psychologists reported concerns about confidentiality, loss of privacy, and resultant loss of trust and honesty, due

to the utilization review procedure. Miller (1996) contends that reviewers seek evidence of lack of medical necessity to deny or restrict treatment and save money; audits of managed care companies reveal a pattern of under-diagnosing and rigid criteria for hospital admissions. The result is pressure on psychotherapists to under-treat clients.

The National Advisory Mental Health Council (1998) recommended future research to on mental health services to determine the minimum premium dollars managed care companies should spend before quality is compromised and to determine how managed care cost-containment strategies affect quality of care; whether fee-for-service or HMO" result in the best patient outcomes. Finally, future studies need to assess how managed behavioral health care treatment guidelines impact clinical outcomes.

The APA and seven other organizations have formed an umbrella group to help develop these guidelines and gather grassroots support for lawmakers who support managed care regulations. The APA umbrella group is hosting press conferences across the country. According to Sullivan (2000, March), the APA Practice Directorate's 2000 State Leadership Conference is being held in Washington DC planned visits to Capitol Hill to encourage representatives to pass managed care accountability provisions.

In California, doctors have joined with patients in Citizens for the Right to Know. In Ohio, the state medical association has joined with patient groups to form Health Advocacy Network (Anders, 1996). As Anders (1996) notes, "...patient advocates and medical lobbyists...grudgingly acknowledged that the only way to challenge the breadth and strength of the HMO-employer lobby was to band together" (p.226). The Center for Patient Advocacy in McLean, Virginia, a nonprofit organization, educates patients about managed behavioral health care and other health issues and helps individuals become

lobbyists working for reform. According to Clay, (1998, April), congress appears to be more readily influenced when consumers and providers voice their concerns to them.

Doctors are grouping together into large practice management organizations or negotiating groups to increase their clout to deal with managed care. Anders (1996), Bilynsky & Vernaglia (1998), and Broskowski (1991) argue for consolidation of doctors into large group practices who make all clinical and financial decisions, contracting services directly with doctors' groups, agencies, and hospitals. According to Frasier (1996), the development of multi-specialty or multidisciplinary mental health groups may help make the managed behavioral health care company obsolete. Bilynsky and Vernaglia (1998) recommend become aware of the possible ethical implications that involvement with managed behavioral health care organizations could yield.

Provider unions, designed to unify health professionals and increase bargaining power with managed care organizations, are developing. The American Medical Association (AMA) voted on this issue in June 1999 (Newsweek, 1999, July). A number of independent practitioners of the New York State Psychological Association have unionized by joining with the American Federation of Workers (Volz, 1999, September). Because of concern that independent practitioners are highly constrained by managed care, unions allow for joint negotiations with managed care. A spokesperson for the American Association of Health Plans, the trade organization for managed care, stated that unionization is about protecting income not quality of care (Volz, 1999, September).

Managed Care Legislation

With health insurance costs more manageable, political concern shifted to issues of quality assurance. State and federal regulators are closely examining managed care because, presently, there is no governing body monitoring them (Anders, 1996). Congress is pursuing increased federal regulation (Sleek, 1998, February; Sleek, 1996, November). Republican Senator Greg Ganske, Iowa, sponsored the "Hippocratic Oath and Patient Protection Act of 1996," prohibiting gag and indemnification clauses in contracts, improper incentive programs, and prevents insurance companies from limiting dialogue about treatment between a provider and patients or the public(H.R. 3222).

Former President Clinton appointed an advisory panel, headed by Former Vice-President Gore, to address reform and urged congress to pass a patient bill of rights requiring better access to health plan information, an independent appeal procedure when reimbursement or treatment is denied, and assuring the confidentiality of medical records (Sleek, 1998). At present, 33 states offer appeals of health plan decisions to an independent expert (Kaiser Family Foundation, 2000, June). Former President Clinton remarked that reform was a necessary development to solve "the problems of cost, accessibility, and quality for all responsible American citizens" (Public Papers of the Presidents, p.1618). The Advisory Commission (1998, July) recommended that consumers receive accurate and easily understood information about health plans, fully participate in treatment decisions, have confidential protection from identification during reviews, have appeals with individuals not involved in initial care decisions, and to have a clear set of measures regarding assessment of clinical quality performance.

In January 1998, the Mental Health Parity Act (H.R. 4058), an amendment to the Health Insurance Reform Act, was passed. The law requires parity or equality for mental health with medical benefit annual and lifetime coverage limits. Russ Newman Ph.D., JD (1998, February), of APA's Practice Directorate, says the law is designed to reduce inappropriate denials of mental health care. State parity law was passed in Vermont; pending legislation exists for New Jersey, New York, Michigan, and Georgia (Clay, 1998, March). Eleven of 29 states with parity laws have broad-based legislation (Foxhall, 2000, June). According to Volz, (2000, March), the GOP Senate version of the bill gives full parity only for biologically-based mental illnesses such as bipolar disorder, depression, and schizophrenia. Empirical studies by the National Advisory Mental Health Council (1998) found parity led to decreases in length of hospital stay.

The 1997 Patient Access to Responsible Care Act (PARCA), sponsored by republican Sen. Charles Norwood, Georgia (Clay, 1998, March) holds managed care companies legally liable for patient injuries directly resulting from reimbursement and treatment decisions and puts treatment decisions back in the hands of consumers and providers (Shearer, 1999, April). By 1997, 32 states passed versions of PARCA (Clay, 1998, March). Opponents are concerned the bill will encourage frivolous lawsuits and raise premiums. PARCA eliminates the provision of the 1974 Employee Retirement Income Security Act (ERISA), exempting and shielding self-insured health plans from liability lawsuits; the law prevents individuals in self-insured plans from seeking legal recourse when direct injury results from treatment denials, inappropriate and inadequate care, or negligent rationing decisions. Currently, only the insurance plans of federal employees can be sued in such circumstances (Anders, 1996; Sleek, 1998, February).

On August 5, 1999, the House of Representatives passed, the "Bipartisan Consensus Managed Care Improvement Act of 1999" (H.R. 2723), amending ERISA and allowing patients to sue their insurance companies for untoward treatment decisions (Rabasca, 1999, November). The act awaits reconciliation with a weaker Senate measure (Rabasca, 1998, September). H.R. 2723 calls for the development of utilization review criteria based upon clinical evidence, prohibits managed care affiliates from being compensated for care denials and requires development of an independent external review panel (Office of Senator Edward M. Kennedy, 2000, June). Corporations like Wal-Mart, IBM, Kodak, and TRW, are lobbying Republicans to prevent the Democratic bill from becoming law; managed care companies frequently contribute to Republican and have added to this influence (April Fulton, personal communication, 2000, July 5).

On July 30, 1999, the Senate version of the bill, "Patients' Bill of Rights Plus Act (S. 1344), was passed. It creates strict controls on medical-record confidentiality and (Office of Senator Edward M. Kennedy, 2000, June). The Secretary of Labor assures that reviews are conducted by licensed physicians, with appropriate expertise using scientific evidence to make decisions, who are not involved with initial decisions and, are not affiliated with, employed or paid by, an insurance company. Noncompliance with review board decisions, by managed care, results in fines up to 10,000 dollars. The act, however, keeps ERISA intact and caps non-economic damages at 350,000 dollars (S. 1344).

The House of Representative's "Comprehensive Managed Health Care Reform Act of 1999" (H.R. 1133) prohibits an insurer from discriminating against a provider who is acting within the scope of their professional license or certification under state law. Most important for psychotherapy, a managed care plan cannot deny coverage for

services not meeting medical necessity unless that determination is made solely by the professional treating the client. The White House has threatened to veto this proposal (Rabasca, 1998, September). A conference committee between the House and Senate this in spring of 2000 ended in a deadlock (Fulton, personal communication, 2000, July 5).

Managed-Care Litigation

A number of lawsuits have been pursued against managed care organizations; initially they involved medical cases or were initiated by federal employees to whom ERISA did not apply. In 1993, Kaiser Foundation Health Plan of Georgia, Inc. was found guilty of medical negligence and ordered to pay 40 million plus to the family of a deceased patient. In 1993, a court ordered Health Net HMO to pay 89.1 million dollars to the family of a deceased cancer patient for whom the insurer would not approve an experimental bone marrow transplant (Anders, 1996). In 1995, a federal Pennsylvania judge, Walter Stapleton, blocked the HMO, U.S. Healthcare, from using the ERISA exemption to move cases from state to federal court to be dismissed, ordering the cases to proceed in state court where previously the cases could not be heard (Anders, 1996).

The Virginia Academy of Clinical Psychology and eight plaintiffs are suing Blue Cross / Blue Shield, and its subsidiary CapitalCare, Inc., for misrepresentation of services, withholding and dictating treatment, and increasing profits by limiting care or reducing services (Rabasca, 1999, February). The managed behavioral health care plan markets that it encourages providing 20 sessions, up to 52 annually. The suit alleges that psychologists who requested "necessary sessions" were penalized for advocating. HMO

caseworkers allegedly refused to pay for necessary sessions and informed psychologists that client's claims would be denied unless clients shifted to an indemnity plan.

In violation of the contractual agreement that psychologists could object to rate changes without expulsion from the network, the HMO allegedly sent a letter to providers that reimbursed rates would be decreased by one-third. The HMO sent letters to clients falsely saying the psychologists opted out of the network. Patients were also denied the full 20 sessions; psychotherapists who requested them were urged to encourage clients to switch to indemnity plans with higher deductibles and copayments. The suit accuses the HMO of attempted cost-savings by purging psychologists from its network; negatively influencing the therapy relationship (Rabasca, 1999, February).

In response to this lawsuit, a DC Federal District Court judge has set a legal precedent by ruling that the managed care company can be sued; by denied the HMO's claim that, under ERISA, it cannot be sued in state court, the judge sent a message that the courts are increasingly skeptical of letting managed care organizations shield themselves with ERISA. The court order will deter managed care companies from trying to remove cases from state courts in the future. (Rabasca, 1999, July/August).

Two other suits have been filed in New Jersey and California by psychological associations, claiming that managed behavioral health care companies use their policies, procedures, and contractual agreements to control patient care (Rabasca, 1999, February). The California suit focuses on false advertising with Aetna, Human Affairs International (HAI), and Adventist who filed promotional material with the California Department of Corporations, describing outpatient mental health benefits as 20 to 50 outpatient visits per calendar year. Providers, however, are provided material stating a four visit limit, a crisis

intervention rather than treatment model, in essence changing the mental health benefit without marketing it as such. Russ Newman Ph.D., JD, APA's Executive Director for Practice, alleges the HMO's are control treatment and provide insufficient treatment for the purposes of profit and usurping provider's treatment decisions. The lawsuit also charges that the HMO's steer patients to providers with low utilization rates to further increase profits (Anonymous, 1998, November).

The New Jersey lawsuit accuses MCC Behavioral Care of impeding the delivery of quality care. Seven psychologists are suing for 27 colleagues who were dropped from the provider panel for practice patterns that were incompatible with managed behavioral health care policy; requesting additional sessions for clients. The suit alleges obstructing access to necessary care to cut costs and maximize profits and obstructing psychologists from making clinical decisions in patient's best interests; interfering with professional judgment and unjustly severing the therapeutic relationship (Sleek, 1998a, February).

The ruling of New Jersey U.S. District court judge Bissell cited three New Jersey laws: health professionals have the right to advocate for patients during utilization review, physicians cannot be removed from hospital staffs without a fair hearing, managed care companies are public services like hospitals, and the psychologists may be protected by a New Jersey Supreme Court ruling stating that employees can sue if they are fired for legally protected behaviors such as pointing out safety hazards and problems in the workplace (Anonymous2, 1998, November; Sleek, 1998a, February).

Two recent lawsuits, supported by APA, involve individual psychologists (Rabasca, 2000, February). A suit against Aetna/U.S. Healthcare by a New Jersey psychologist claims wrongful termination for refusing to violate New Jersey's Peer

Review Act. The Peer Review Act requires psychologists to keep details of patient's treatment and conditions confidential, even if a patient releases the information; only case numbers, administrative information, modality, duration, and frequency of treatment, diagnosis, functioning, and level of functioning information can be released. A Florida suit against Magellan behavioral health care claims that by arbitrarily terminating care against the psychologist's warnings that this would be detrimental to patient's well-being, the insurer inappropriately interfered with the doctor-patient relationship. The suit alleges a breach of contract for failing to allow the professional to exercise his professional judgment in providing services (Rabasca, 2000, February).

Russ Newman, Ph.D., JD says these cases highlight the managed care industries propensity for using capitation and other financing mechanisms to fuel profits at the expense of quality care and for hold psychotherapists solely responsible for care while restricting their ability to fulfill that responsibility (Sleek, 1998a, February). Newman (1997, November) stresses the importance of the federal rulings holding managed care companies accountable as entities providing health care to the public.

This contrasts with the defense of managed behavioral health care companies that they only manage benefits for the third-party payer and are not responsible for treatment outcomes. Newman, Ph.D., JD says these cases are strengthened when state laws have favorable provisions pertaining to quality of care issues such as consumer protection (Anonymous2, 1998, November). The Virginia, California, and New Jersey lawsuits, Newman says, are strategically designed check and balance measures to circumvent the ERISA protection managed care organizations have been using to avoid state litigation and to foster the dismantling of counter-therapeutic managed care policies/procedures.

The main foci of these APA-supported legal cases are managed behavioral health care's use of policies and contractual provisions to control the delivery of health services and their use of financial arrangements to create disincentives for delivering quality patient care (Newman, 1998, November). The APA's strategy is to expose the degree that managed care actually make treatment decisions (Alvarez, 1998, September). Newman says the goal is to have the courts recognize managed behavioral health care for the role they play in influencing patient treatment decisions; to hold them legally accountable, as psychotherapists are, for treatment decisions; not only as business organizations governed by contract law but as deliverers of health care (Rabasca, 1998, November).

Though managed behavioral health care practices are viewed by some as professionally objectionable, the former are not held legally accountable for their decisions. Legal cases were sought in which patient well-being was at stake because managed care organizations were now participants in patient care decisions (Rabasca, 1998, November). The goals are to force attention onto quality assurance issues, hold managed care responsible for the consequences of arbitrary care decisions, and stop them from usurping the decision-making power of professionals (Foxhall, 1999, October).

Managed Care Guidelines for Mental Health Treatments

The treatment decisions of many managed behavioral health care organizations are guided by clinical criteria regarding treatment admission and planning, level of care, change in treatment intensity, continuance of care, discharge and referrals. These criteria are reportedly based on a combination of empirical literature and codification of clinical experience, in unknown combinations (Beutler and Davidson, 1995; Pallak, 1995).

Newman and Tejada (1996) suggest the clinical care criteria are only concerned with cost containment and consumer satisfaction, though the latter has a low correlation with treatment's effect on functioning or quality of life. Utilization review criteria are debated at the state level where laws require appropriate health care specialists to design an insurance plan's utilization review criteria, rather than let case reviewers with limited knowledge of mental disorders make decisions (Sleek2, 1996, November).

Karon (1995) suggests that, when designing policies for treatment decisions, some managed behavioral health care companies ignore the research literature designed to increase quality care. Many managed care contracts are sold as providing 20+ sessions of psychotherapy per year; however, there is pressure to terminate treatment earlier, providing fewer than 10 sessions and it is unclear if managed behavioral health care companies research results are used to arrive at this optimal number.(Karon, 1995). These companies have much latitude with respect to eligibility criteria for outpatient mental health. DeLeon et al. (1991) suggest amount and breadth of services are determined less by law than interpretation of loose guidelines. Anders (1996) discussed eight cases denied treatment coverage at United Behavioral Health (UBH) in Rhode Island in 1995 that, upon review by two Harvard Medical School psychiatrists, were determined to have met the criteria of medical necessity established by UBS.

Professionals are confused about what validly constitutes minimally necessary information or medically necessary criteria. Stanley Moldawsky (1995), says, "This has become a euphemism for suicidal, dangerous depression, hallucinating, etc., and all other serious problems are the problems of the worried well and not to be covered by insurance" (p.36). Miller (1996) argues that managed care organizations unethically push

for use of short-term or time-limited therapy by coercing psychotherapists with bonuses, report cards, and dismissal from provider panels for providing long-term treatment; use of such therapeutic techniques without proven clinical efficacy constitutes under-treatment and could be construed as abandonment.

Support for claims that clinical decision-making is not based on empirical data comes from a February 1995 meeting of the HMO Mental Health Research Consortium, held at Kaiser Permanente's Division of Research in Northern California, where researchers from across the United States convened to create an agenda to develop policy recommendations based on research findings. Conference members advocated for research conducted by investigators who understood the issues, structure, limitations, and advantages of a managed-care setting. The meeting was an opportunity to capitalize on national data being collected on clinical outcomes; studies that examine clinical status, functional status, patient satisfaction, quality of life, and short- and long-term costs (Miller and Farber, 1996). This goal supports those who contend that outcome research needs to focus on multiple measures of client functioning from multiple perspectives.

The President's Advisory Commission (1998, July), in the proposed "Patient Bill of Rights and Responsibilities," recommended that clinical protocols, practice guidelines, and utilization review standards be made available upon request. Currently, federal regulations do not require managed care organizations to disclose this information to providers or the public. According to April Fulton (personal communication, 2000, July) states differ with respect to requiring the release of clinical criteria. The House "Comprehensive Managed Health Care Reform Act of 1999" (H.R. 1133) requires a managed care company to provide a description of the clinical review criteria relating to

the client's condition, to providers, professionals, and enrollees; how the screening criteria and computer algorithms were developed and are used in treatment decisions. Additionally, utilization review criteria are to be developed with the involvement of appropriate professionals, based upon scientific principles and the most recent evidence.

In late 1999, this researcher placed calls to several managed behavioral health care companies seeking to obtain information regarding the criteria or guidelines for mental health treatment decisions; how the criteria were developed and treatment decisions were made. A representative from Magellan Behavioral Health Care, managers at that time of Aetna / Human Affairs International, Greenspring, U.S. Healthcare, Merritt Behavioral Health, and Pru-Care, stated he would mail this information. It was not, however, received. He did state that criteria were based upon studies from the American Psychiatric and Psychological Associations and other related studies.

A representative from First Option, which at the time managed Physicians Health Services as well, reported that their company did not have written material on the subjects and did not provide written information regarding policies. Cigna Managed Care Company reported that this information could be obtained via the Internet where the criteria for medical necessity were detailed but no information was available regarding how treatment guidelines were developed. The representative also stated that the clinical criteria for mental health and substance abuse treatments were 90% based on American Psychiatric Association clinical guidelines and 10% based on practitioner's experiences.

Value Options personnel, which at the time managed Group Health Incorporated and some divisions of U.S. Healthcare, provided similar information with similar results. Additionally, this company's representative stated that the criteria change with time and

vary depending on the circumstances of the individual. Personnel from the following companies were either uninformed about the material sought by this writer or continued to transfer the telephone call to other extensions that did not answer or for whom messages were left and no return phone calls received: Oxford Behavioral Health, Guardian, and New England Financial: One Health Plus.

Navigating the telephone networks of these companies was a difficult and long process. Many of the personnel were unfamiliar with the information sought and many were unable to direct the telephone call to supervisors or departments who were knowledgeable. It is worthwhile pursuing whether the information sought regarding development of clinical criteria and treatment decisions are now available in a detailed format. Two currently practicing psychotherapists have reported to this researcher that they also have been unable to secure similar written materials.

Psychotherapy Outcome Studies: The Effectiveness of Psychotherapy

Meta-analytic studies of psychotherapy outcome generally support its effectiveness; people needing mental health services who receive psychotherapy have better outcomes, on average, than those who do not (Clum, Clum, & Surls, 1993; Lambert & Bergen, 1994; Lipsey and Wilson, 1993; Matt, 1989; Shadish, Matt, Navarro, Siegel, Crits-Christoph, Hazelrigg, Jorm, Lyons, Nietzel, Robinson, Prout, Smith, Svartberg, & Weiss, B. 1997; Shadish & Ragsdale, 1996; Shadish, Montgomery, Wilson, Wilson, Bright, & Okwumabua, 1993; Shadish & Sweeney, 1991; Svartberg and Stiles, 1991; Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997; Weisz, Weiss, Han, Grandner, & Morton, 1995). Meta-analysis is an integration technique in which individual

study results are abstracted into one database for statistical comparison of different treatments, the impact of methodological features and other variables of interest, through regression analysis (Lambert & Bergen, 1994; Lipsey and Wilson, 1993).

One of the earliest reviews of the literature by Eysenck in 1952 found no positive effects of psychotherapy; the methodological and statistical sophistication of meta-analyses enabled such data to be reanalyzed and concluded that psychotherapy is beneficial. Lambert and Bergen (1994) conducted a meta-analysis of adult outpatient psychotherapy clients with anxiety disorders. In comparison to no-treatment controls, clients improved 0.51 to 2.10 effect size units. Psychotherapy accounted for 10% of the variation in outcome; it increased the success rate from 34% to 66%.

Though some patients relapse, there is evidence the effects of psychotherapy can be delayed; improvement continues with time. Gallagher-Thompson, Hanley-Peterson, and Thompson (1990) found that, in depressed older adults, improvement rates at post-treatment, 12 and 24 months follow-up were 52%, 58% and 70%, respectively (in Lambert & Bergen, 1994). In contrast, Andrews and Harvey (1982, in Lambert & Bergen, 1994) found that improvement is stable for months following treatment but eventually declines 0.20 effect size units per year. Lipsey and Wilson (1993) conducted a meta-analysis of 302 psychotherapy meta-analyses from 1977 to 1993. Results indicated that the average treatment group scored 0.47 standard deviations above control groups, averaged across outcome measures; a 62% success rate for treatment groups versus a 38% improvement for controls.

A well-cited, controversial survey of psychotherapy outcome and effectiveness was conducted by Consumer Reports magazine (Consumer Reports, 1995, November).

Martin Seligman, past president of the APA's Clinical Psychology division and past director of training at the University of Pennsylvania, consulted. Of 4,000 subscribers who received therapy between 1991-1994, 87% felt good or significantly improved; clients who formed a good relationship with their therapists experienced the most improvement. Longer psychotherapy was associated with better outcome: clients treated for more than six months reported greater gains (50% versus 33% improvement); 50% recovered after 11 weeks and 75% after one year. Of those in managed care plans, poorer outcomes were reported when coverage limited the length and frequency of therapy. Coursey et al. (1997) contend that outcome data needs to consider consumer satisfaction; real contributions of psychotherapy are overlooked by narrow outcome measures

Shadish et al. (1993) conducted a meta-analysis of 163 marital and family psychotherapy studies from 1963-1988, that employed randomization and an average of eight therapy sessions. At three weeks post-treatment, psychotherapy subjects fared better than 70% of controls; a 62% success rate. Active treatments accounted for 6% of outcome variance. No significant differences were found between theoretical orientations. Dobson (1989) conducted a meta-analysis of Beck's cognitive therapy for depression. Twenty-eight studies were analyzed that used the Beck Depression Inventory (BDI). Results indicated that cognitive therapy subjects fared better than 98% of controls; compared with pharmacotherapy, cognitive therapy produced an effect size of 0.53 or a 70% success rate. Length of therapy was not significantly correlated with BDI scores.

Meta-analysis of child and adolescent therapy have revealed efficacy with these populations. Weisz et al. (1995) analyzed 150 outcome studies between 1983-1993. Only published studies were included, a methodology that produces larger effect sizes.

Average treatment effect size was 0.54. Behavioral interventions were marginally, significantly more effective than non-behavioral ones, after controlling for problem type. Studies conducted in laboratories produced larger effect sizes than studies in clinics. Effect sizes were larger for dependent measures related to target problems/symptoms,

Svartberg and Stiles (1991) conducted a meta-analysis of 19 studies of short-term psychodynamic psychotherapy in clinic settings from 1978-1988. Short-term therapy was defined as anything less than 40 sessions. Results indicated that short-term dynamic therapy was significantly superior to no treatment controls at post-test. Short-term therapies were inferior to behavioral, cognitive behavioral, and experiential therapies at posttest and 12 month follow-up but not at 6 month follow-up. Duration of treatment was clinically, not statistically, significant with time-limited treatment more effective than time-unlimited. Svartberg and Stiles (1991) found that the efficacy of short-term therapy improved when treatment was greater than 12 sessions.

Psychotherapy research has grown to where specific disorders and approaches are being studied. Clum et al. (1993) conducted a meta-analysis of treatments for panic disorders for studies between 1964-1990. No significant differences were found between treatment and control groups. The most effective treatments were coping strategies, flooding, exposure, followed by drugs in combination with therapy. Shadish and Sweeney (1993) examined 163 randomized controlled studies of marital and family therapy outcome, specifically addressing theoretical orientation as a moderator. The authors hypothesized that behavioral treatments produce larger effect sizes because their dependent measures are more reactive and treatments are more often manualized. They

found behavioral treatments produced an effect size of 0.56 and non-behavioral treatments were 0.54, both significantly different from zero but not one another.

The meta-analytic technique has raised concerns of researchers striving to prove the efficacy and effectiveness of psychotherapy approaches. Suggestions for improving the technique for use with psychotherapy outcome studies, and the individual outcome studies on which they are based, are numerous. Lipsey and Wilson (1993) discuss methodological issues that can positively alter effect size estimates: sample sizes, outcome measures, and statistical tests conducted, making it unlikely that homogeneity of variance, a validity check for the approach, is met (Chambless and Hollen, 1998).

Effect size estimates for treatment groups, when nonrandom assignment to groups is used, result in slightly lower effect sizes than randomized studies due to level of control (Lipsey and Wilson, 1993 and Ragsdale, 1996). Random assignment to conditions is a gold standard defining clinical trial research as it is conducted today to develop EVT and EST. Shadish and Ragsdale (1996) conducted a meta-analysis of 100 marital and family psychotherapy studies that contrasted treatment with control conditions. They separated studies by whether or not subjects were randomly assigned. The average effect size for randomized experiments was 0.60 and for nonrandomized experiments was 0.08. When various covariates were controlled, effect size dropped from 0.52 to 0.27.

When placebo control groups, rather than no-treatment groups, are employed, effect sizes for specific treatments tend to be smaller because placebos produce effects that represent other therapy moderator variables such as attention and expectancy, though placebos allow for assessment of direct treatment effects above and beyond that produced by these moderator variables. Clum et al. (1993) suggest that, in order to compare studies

fairly, studies need to adopt similar control groups and dependent measures because the choice of a comparison group helps determine whether a treatment effect is realized.

Shadish and Sweeney (1993) define mediating variables as the mechanisms through which independent variable influence dependent variables; the therapy process variables. Moderator variables are qualitative or quantitative variables that effect the direction and strength of the relationship between independent and dependent variables. They include location of treatment, treatment dosage, measurement reactivity, sample size, therapist experience, use of manuals, length of therapy, experimenter allegiance and blindedness. Weisz et al. (1995) caution that researcher allegiance to particular therapies or techniques can produce successful outcomes because of expectancy effects; an artifact that cannot be controlled for without random assignment of therapists in a study.

According to Howard et al. (1997), with the efficacy and effectiveness of psychotherapy established, mediator and moderator variables determine the how, what, where, and with whom psychotherapy can be more successful. Future research needs to address these variables, along with characteristics of the recipients, providers, and settings that most influence such results. Shadish et al. (1997) note that laboratory research results are misleading because research parameters do not approximate actual therapy in terms of homogeneity of client characteristics, specially trained therapists, use of narrow and specific therapy procedures, scripted treatment manuals, and artificial settings. Therapy under controlled conditions leads to larger effect sizes than for clinic therapy and quasi-experimental designs.

Howard et. al. (1997) caution that RCT studies maximize internal validity but sacrifice external validity; doing little to inform client and therapist about which therapy

works for which client at this point in time, in this setting. Shadish et al. (1993) support future studies that directly compare different orientations to one another on similar outcome measures so the confounding which occurs when studies are compared can be controlled and a purer comparison established. With RCT, psychotherapists can not determine each therapy's efficacy relative to others.

Characteristics of Effective Psychotherapy: Common Factors

Evidence from psychotherapy research suggests the primary variables that mediate change, and account for much of the improvement, are the client, the therapist, therapy relationship, and setting in which therapy is conducted. Lambert and Bergen (1994) label these variables nonspecific or common factors, defined as, "dimensions of the treatment setting (therapist, therapy, client) that are not specific to any particular technique" (p. 149). Through meta-analysis, Lambert and Bergen (1994) accumulated a list of 32 factors, that are associated with positive outcomes, including catharsis, structure, mitigation of isolation, positive relationship, therapist and client active participation, reassurance, release of tension, therapeutic alliance, therapist warmth, respect, empathy, acceptance, genuineness, expertise and trust.

Learning factors consist of advice, affective experiencing, assimilation of problematic experiences, changing expectations, cognitive learning, corrective emotional experience, feedback, insight, and rationale. Action factors include behavioral regulation, cognitive mastery, encouragement of facing fears, taking risks, mastery efforts, modeling, practice, reality testing, success experience, and working through (Lambert and Bergen, 1994). Lambert and Bergen (1994) suggest the therapy relationship is most predictive of

successful therapy outcome. A positive therapeutic alliance includes the client's affective feelings toward the therapist and capacity to work in therapy, the therapist's empathic understanding and involvement, and client-psychotherapist agreement on goals.

The following additional common factors also effect the outcome of psychotherapy: therapist and client gender and personality, cultural background, therapist theoretical orientation, severity and number of symptoms, motivation to complete treatment, how change is measured, and duration of therapy. Relevant psychotherapist attributes include empathy, maturity, intelligence, capacity for reflection, a collaborative working style, patience, discretionary self-disclosure and confrontation, ability to facilitate autonomy, providing reassurance and feedback, directness, structuring sessions, and properly timed interventions and interpretations. Lambert and Bergen (1994) found that more helpful therapists had more skill and interest in helping clients, were better adjusted, psychologically, and had a strong, positive relationship with clients.

Other researchers have found client variables to be more indicative of positive psychotherapy outcome. Citing the 1977 meta-analysis by Smith and Glass, Wilson (1995) notes that client factors accounted for the largest amount of outcome variance, followed by therapist variables. Client attributes of low self-esteem and self-concept, poor interpersonal relationships, low anxiety tolerance, low motivation, and a high need for fulfillment are positively related to therapy deterioration. A factor in maintaining treatment gains is the degree to which clients and therapists view change as resulting from direct client efforts: internal locus of control. Client level of trust, cognitive learning, reality testing and practicing new behaviors are all related to positive outcome.

Some clients are negatively effected by psychotherapeutic interventions but deterioration may not be the product of the psychotherapy itself. This issue has implications for the selection of clients for certain techniques and procedures as well as training and monitoring of psychotherapists. According to Lambert and Bergen (1994), one important interaction involves patient diagnosis and degree of disturbance with techniques aimed at breaking down or challenging coping strategies or defenses; more severely disturbed clients, including those with psychotic and borderline personality disorder diagnoses, show more deterioration with these intervention techniques.

The literature is replete with meta-analyses concluding that no one school or form of psychotherapy is superior to any other, suggesting the importance of common factors. Persons and Silbershatz (1998) propose that knowledge in our field would be further advanced by focusing on basic change mechanisms and less on which school of psychotherapy is most efficacious; identifying the effective ingredients of psychotherapy, how they can be maximized, and how therapists can be trained to use them effectively. Wilson (1995) stresses that all psychotherapies share common, probably influential factors. Examination into the psychotherapy process within sessions may prove fruitful to understanding of how common factors positively affect psychotherapy outcome.

A recent study of Beck's cognitive therapy for depression highlights the importance of common process variables in psychotherapy outcome and indicates this kind of ecologically-valid, clinical research. The underlying change processes of Beck's therapy have not been delineated. Castonguay, Goldfried, Wiser, Raue, & Hayes (1996) studied the impact of two common process variables and one cognitive therapy variable on scores on the BDI, Hamilton Depression Rating Scale (HDRS), and the Global

Assessment Scale (GAS). for 30 depressed clients. The four psychotherapists, with no prior experience conducting cognitive therapy, received 6-14 months of training.

Three predictor variables were analyzed: working alliance, client affective experiencing, and therapist's focus on linking a client's distorted thoughts to effects on depressed mood. Results of regression analyses indicated that cognitive therapy techniques had a negative impact on depression scores while two common factors were positively correlated with reductions in depressive symptoms: working alliance predicted improvement on all post-treatment measures and affective experiencing predicted improvement on post-treatment BDI scores. The negative impact of the cognitive therapy techniques stemmed from rigid adherence to the treatment manual to the neglect of therapy relationship issues (Castonguay et. al., 1996).

The Wampold, et. al. (1997) meta-analysis of psychotherapy outcome studies found that the active treatments accounted for only 10% of the variance in treatment effect sizes. In 1991, a literature review by Lambert found that common factors accounted for 30% of client improvement; 40% of improvement was attributed to environmental influences, 15% to expectancy, and 15% to the specific techniques used (in Granello and Witmer, 1997). Granello and Witmer (1997) recommend that standards of care include results from studies of common factors as well as specific techniques, especially if technique is further proven to account for a minor proportion of client progress. Lambert and Bergen (1994) suggest that common factors are activated in different ways by the techniques of particular theoretical orientations or treatment approaches. Because some common factors are so closely interwoven with certain specific techniques, separating

active ingredients from common factors may prove to be futile; techniques gain effectiveness from their interaction with the individual's involved.

Additional support for the magnitude of effect of common factors comes from psychotherapy research in which placebo controls are used. Because only the active treatment in question is missing from the placebo control group, magnitude of changes common to both placebo and active treatment groups represent common factors across groups. In a meta-analysis of such studies, Lambert and Bergen (1994) found that 66% of placebo group patients and 79% undergoing active psychotherapy improved compared to no-treatment controls. Placebos are often successful because they produce expectations for improvement, a common factor, of a degree comparable to bona-fide treatments.

Attempts to isolate the effects of specific therapy techniques, interventions, or approaches or active treatment ingredients may be facilitating the gap between researcher and clinician. Managed care policies have moved researcher's attention in this direction, as the field seeks specific proof of psychotherapy's effectiveness. The gestalt view of therapy has yielded to attempts to break down the process, moving attention away from common factors. As Goldfried (1998) noted, theoretically pure psychotherapies are neater and easier to study but less representative of actual clinical practice. Because each psychotherapy approach is not purely distinctive from all others, common factors, and their interaction with treatment approaches, may turn out to be the variables that facilitate psychotherapeutic change (Goldfried, 1998).

Time-Limited vs. Time-Unlimited Therapy: Efficacy and Effectiveness

Controlling health care costs is a primary goal of managed behavioral health care. As such, a prominent issue concerns the comparison between short-term and long-term psychotherapy techniques. Kiesler (2000) asserts that "Short-term therapy clearly becomes the treatment of choice...providers cannot routinely allow long-term care alternatives. It does not help if...a care providers has no treatment at all to offer five other patients in the population who have similar problems...Both short-term therapy and nontraditional therapy become central to any form of capitation" (p.485).

In order to process all patients who need psychotherapy, Kiesler (2000) suggests a good enough treatment approach where, though longer psychotherapy might produce better outcomes, the results are good enough to avoid relapse and meet the insurer's financial capitation requirements. Short-term therapy, empirical validated, allows psychotherapists and managed behavioral health care companies to expand needed access to care. Kiesler (2000) adds, however, that short-term treatment cannot be too short, where patients return later for the same, uncorrected, problems. As Giles and Marafiotte (1998) note, some managed behavioral health companies have decreased mental health services beyond appropriate standards. Miller (1996) asserts that the effectiveness of the newer, ultra-brief psychotherapies supported by managed care, have not been empirically validated. Future studies need to consider the effect of time limits on psychotherapy outcome, with different clients with varying symptom severity, as a minimum quantity of psychotherapy is a precondition for providing quality treatment (Miller, 1996).

The dose-response curve, developed by Howard, Kopta, Krause, and Orlinsky (1986), is often cited as support for the optimal number of therapy sessions. The curve

suggests that 50% of clients are improved by the eighth session; 75% are improved by the end of 6 months of weekly treatment. Psychological ills are alleviated faster with psychotherapy; the amount of change in untreated groups is much less (in Lambert & Bergen, 1994). Lambert and Cattini-Thompson (1996) found results can be achieved for 50% of clients in 5-10 session; 20-30% require long-term or alternative interventions and the remaining minority need ongoing care (in Granello & Witmer, 1998).

Kopta, Howard, Lowry, and Beutler (1992) found that 74-89% of chronically distressed clients were clinically and significantly improved by the end of the 52 session; 60% of characterologic problems were alleviated in the same treatment time frame (in Lambert & Bergen, 1994). Bilynsky and Vernaglia (1998) say most clients attend only a short number of sessions. Citing a study by Howard, Davidson, O'Mahoney, Orlinsky, and Brown from 1989, they report that 68% of patients attend 26 or fewer sessions and 32% had more than 26 sessions. Bilynsky and Vernaglia (1998) suggest that externally-imposed session limitations may not affect the length of treatment for many clients.

Lambert and Bergen (1994) analyzed The Second Sheffield Psychotherapy Project of depression comparing cognitive-behavioral and psychodynamic-interpersonal therapies. The results showed a significant interaction between severity of depression and duration of treatment: clients with mild to moderate depression had as much success with eight therapy sessions as with 16 sessions while those with severe depression fared best when treatment was 16 sessions long. Thus, managed behavioral health care cost containment strategies can, in part, be validly based on the severity of this disorder.

In the Consumer Reports (1995, November) survey of psychotherapy, longer psychotherapy was associated with better outcome: 50% of those who stayed in therapy

for more than six months reported greater gains than the 33% of clients in treatment less than six months. Additionally, 50% of clients recovered after 11 weeks while 75% recovered after one year. In contrast, Dobson's (1989) meta-analysis examined length of therapy as a moderator variable for Beck's cognitive therapy and found no significant correlation on post-treatment BDI scores, concluding that cognitive therapy produced change in a relatively short period of time; no reference is made to the mean or range of sessions employed. Seeking to develop quality care data, a United Behavioral Health managed care company study and found that improvement at termination was determined by absence of comorbid disorders, completion of treatment goals, and participation in more than 12 treatment sessions (National Advisory Mental Health Council, 1998).

In a meta-analysis of short-term psychodynamic therapy, Svartberg and Stiles (1991) found that longer variants (greater than 12 sessions) significantly increased the efficacy of these approaches as compared with no treatment control groups. Short-term psychodynamic therapy was significantly superior to no treatment at posttest, though differences diminished as methodological quality of the studies increased. Controlling for subject characteristics, clinical improvement rates were 55% for the treatment group versus 45% for controls: a 10% clinical improvement rate. Also, time-limited treatment more significantly more effective than time-unlimited treatment. Noting that statistical significance does not guarantee clinical significance, Svartberg and Stiles (1991) suggest time-limitations, even when therapy is of longer duration, facilitate treatment progress.

Karon (1995), cited a 1981 study with VandenBos where psychoanalytic therapy for schizophrenia fared better than medication alone over a four year period. An average of 70 therapy sessions were provided. Over the four years, health-care costs decreased by

nearly 50%, largely due the decreases in re-hospitalization. Noting escalating costs of inpatient care, psychotherapy's long-term cost-effectiveness was substantial. Karon (1995), believes that if the goal is to have clients say they feel better, then three session will suffice; if the goal of treatment is symptom change, 20-50 session are required, and if the goal is increased work efficiency, 100 or more session must be made available. Knapp (1996) surveyed 147 licensed psychologists in Pennsylvania and found that, though managed care was perceived as being punitive toward psychologists advocating for continued care, only 5% reported expulsion from provider panels for doing so; some psychologists did note a decrease in referrals following instances of such advocacy.

Many concerns with managed behavioral health care center around treatment length, authorization, or care denials. As Anders (1996) notes, "Outpatient therapy can be truncated to the point that short-term suicide prevention becomes the only goal, with little effort to help a person regain the stability needed to...function well in everyday life. Barriers meant to prevent excessive use of psychiatric hospitals can rise so high that even the truly sick aren't admitted for overnight stays or are discharged too soon" (p.157).

Impact of Theoretical Orientation on Psychotherapy Outcome

The Dodo bird conjecture, coined in 1936 by Rosenzweig, is an analogy from the Alice in Wonderland fable. It states, when psychotherapies intended to be therapeutic are compared, the true differences among all such treatments are zero; differences measured by effect sizes also should approach zero (Wampold, et. al, 1997). Luborsky, et. al. concluded similarly in their 1975 meta-analysis of psychotherapy outcome studies.

This hypothesis runs counter to the current movement to establish empirically validated treatments (EVT) and empirically supported treatments (EST); identifying the unique ingredients of treatments most responsible for the efficacy of psychotherapy with specific disorders. The precision and degree of internal validity of the research reduces error variance, allowing for greater confidence in the conclusions about active therapy ingredients or specific therapeutic factors, magnifying differences between therapies.

The sheer number of psychotherapy approaches is overwhelming. Granello and Witmer (1997) report there are currently over 400 approaches to psychotherapy. The more prominent are psychoanalysis, psychodynamic, cognitive, behavioral, humanistic, interpersonal, client-centered, existential. Lambert and Bergen (1994) make the distinction between verbal or insight-oriented psychotherapies (psychodynamic and humanistic) and action psychotherapies (behavioral and cognitive).

In a 1990 study, 68% of psychotherapists reported their orientation as eclectic, primarily a combination of psychodynamic, cognitive-behavioral, humanistic, and systems techniques. Few studies have addressed the efficacy of these combination psychotherapies (Jensen, Bergen, & Greaves, in Lambert & Bergen, 1994). In a study of psychologists in private practice, Gold and Shapiro (1996) observed that an increase in managed behavioral health care affiliation coincided with a shift in the orientations psychologists endorsed; a 16% drop in identification with a psychodynamic approach and a 12% increase in identification with an eclectic or cognitive-behavioral approach.

There is conflicting evidence regarding the superiority of one school of thought or psychotherapy approach over another. Shadish et al. (1993), in their meta-analysis of marital and family psychotherapies, categorized approaches into the following groups:

behavioral and psycho-educational, systemic, humanistic, psychodynamic, eclectic, and unclassified. They found all psychotherapies, except humanistic approaches, reached statistical significance. Non-behavioral marital psychotherapies had a smaller effect size than behavioral psychotherapies; however, there were no significant differences between theoretical orientations, after statistically controlling for moderator variables.

Lambert and Bergen (1994) discuss a number of studies in which behavioral and verbal psychotherapies were directly compared, the largest being the National Institute of Mental Health Collaborative Depression Study which marked a change from studying psychotherapy as it is actually practiced to studying ideal therapy guided by manuals. Cognitive-behavioral therapy was compared to interpersonal psychotherapy; a combination of dynamic and humanistic approaches. With an average of 16.2 sessions and outcome measures of symptoms and adjustment from multiple perspectives, the results found no differences between the two therapy groups, even on measures thought to be differentially sensitive to each school of thought. The only differences that emerged concerned initial level of depression where interpersonal psychotherapy proved to be superior when severely depressed persons were treated (in Lambert and Bergen, 1994).

Wampold, et. al. (1997) conducted a meta-analysis of psychotherapy outcome studies in which there was at least one direct comparison between treatments of different theoretical orientations where a description of the psychotherapy was provided along with a treatment manual if one existed and the active ingredients of the therapies were identified. A total of 277 comparisons were made. The range of effect sizes was 0.00 to 0.21 with aggregate effect size results hovering around zero. The authors concluded there were no statistically significant differences between treatments but caution against

equating psychotherapies; some psychotherapies are specific to certain disorders, others have positive results with a variety of disorders, and some specific disorders can be positively affected by many treatments. Wampold et al. (1997) suggest that the efficacy of treatments are comparable not interchangeable.

Wampold et al. (1997) offer a number of caveats when evaluating research on differences between theoretical approaches. Classifying treatments into broad categories (e.g. cognitive-behavioral, psychodynamic, humanistic) creates problems for testing relative efficacy because it becomes impossible to evaluate differences between specific therapies within each class. Second, studies concluding there are large differences between treatments, often when treatment is compared to controls, can produce such results because of the artifact of researcher allegiance; outcome measures chosen are maximally sensitive to the particular interventions of the focused treatment; e.g. behavior therapy for anxiety will show positive effects on measures addressing anxiety symptoms.

Third, conclusions about psychotherapy differences are usually based on studies that did not directly compare various treatments; conclusions are confounded by differences between the studies which compared each prospective psychotherapy with control groups. Numerous client, therapist, setting, and methodological variables confound psychotherapeutic orientation effects with outcome. These authors support the development of studies in which psychotherapies are directly compared on the same outcome measures and in which confounds or mediating and moderator variables can be relatively equal across treatment groups. Shadish and Sweeney (1993) suggest that treatment-treatment comparisons are not included in meta-analysis because treatment-control comparisons produce larger effect sizes and are easier to analyze.

Lambert and Bergen (1994), in their meta-analysis of outcome studies, suggest that the apparent superiority for behavioral, active psychotherapies can be explained by methodological artifacts. They cite a 1982 meta-analysis by Shapiro and Shapiro which examined 143 studies in which two treatments were compared. The results found an effect size for cognitive and behavioral approaches of 1.00 and 1.06, respectively, while dynamic and humanistic psychotherapies only resulted in effect sizes of 0.40. Differences were attributed to researcher allegiance and methodology (in Lambert and Bergen, 1994). When Robinson (1990) controlled for researcher allegiance, the differences between psychotherapies was negated. Lambert and Bergen (1994) suggest using within study comparisons of different treatments in meta-analytic reviews so other influential, confounding variables can be controlled; results suggesting superiority of one treatment over another must identify or explore the reasons for the differences.

Comparing different psychotherapies is more difficult than comparing treatment with controls and placebos because of difficulties with using similar measures of change and progress for very different theoretical approaches. Deciphering the specific agent of change is difficult when researchers cannot hold all but one factor constant between theoretical approaches. Additionally, certain variables cannot be controlled because they are inherent to the psychotherapy itself (Borkovec and Castonguay, 1998).

Lambert and Bergen (1994) suggest that cross-study comparisons of therapies produce invalid, unreliable results because many other important variables differ across studies. As such, the specific causative ingredients of change, in EVT research, have not been established. EVT research can only conclude that a treatment is superior to no-treatment or a placebo or caused improvement beyond chance, factors common to all

psychotherapeutic relationships, or the passage of time or repeated testing (Borkovec and Castonguay, 1998). Lambert and Bergen (1994) believe that the use of placebo controls is not useful for helping to isolate active psychotherapeutic ingredients; research needs direct, meaningful comparisons between treatments.

Smith, Glass, and Miller (1980, Wampold, et. al.,1997) found that only 10% of outcome variance is due to theoretical orientation. Shadish et al. (1993) also found that only 6% of the outcome variance in marital and family therapies was due to theoretical orientation or the active treatments employed. However, Shadish and Sweeney (1993) propose that theoretical orientation does make a difference on psychotherapy outcome through its effects on mediating variables, not study outcome itself; orientation is only one of the variables responsible for outcome differences. They examined 163 randomized controlled studies of marital and family therapy, specifically looking at theoretical orientation as a moderator variable and hypothesizing that behavioral treatments produce larger effect sizes because dependent measures are more reactive, treatments are often manualized, and publications are likely to be about behavioral interventions.

Shadish and Sweeney (1993) found behavioral treatments produced an effect size of 0.56 and non-behavioral treatment resulted in an effect size of 0.54; both significantly different from zero but not one another. Five intervening variables were found to be significant for outcome in this analysis: treatment location (behavioral treatments in university settings produced larger effect sizes than comparable non-behavioral treatments and behavioral treatments in non-university settings), measurement reactivity (behavioral treatments using high reactive measures had significantly larger effect sizes than studies using measures of medium to small reactivity and non-behavioral treatments

using low reactive measures had higher effect sizes than comparable behavioral measures), measurement specificity (specific, manipulable measures have higher effect sizes), and number of subjects (small sample size studies need larger effect sizes to reach significance). The authors conclude that orientation has an effect on outcome through the therapeutic and scientific choices researchers; these factors favor behavioral therapies but when those variables are equivalent, the differences between therapy types disappears.

Shadish and Ragsdale (1996) highlighted the importance methodology can have on results. In their meta-analysis of family and marital therapies, based on random and nonrandom assignment to groups, they found a significant advantage for the former. They stress the importance of evaluating studies comparing treatments, for randomization; approaches or techniques tested frequently or amenable to testing with randomization show superior results which must be tempered with being confounded with design type.

In contrast, Weisz et al. (1995), in their meta-analysis of child and adolescent psychotherapy outcome studies, found no support for the Dodo Bird hypothesis. According to their data, behavioral approaches showed more substantial psychotherapy effects than non-behavioral treatments, even after controlling for outcome measures that were similar to treatment activities and therefore likely to produce larger effect sizes for those treatments. They caution against extrapolating strong conclusions from their data because only 10% of the studies they analyzed were non-behavioral.

Granello and Witmer (1997) hypothesize that different psychotherapies achieve similar goals through different processes and that common factors across psychotherapies account for most of the curative change associated with each school of thought. They propose that research strategies are not powerful enough to detect differences between

psychotherapies. Kazdin and Bass (1989) contend that the Dodo Bird hypothesis, and the resulting theory that the effects of psychotherapy come from common factors, must consider the fact that psychotherapy outcome studies often lack sufficient power to detect differences between treatments that are small or medium in effect. The authors reference Cohen's formulation of effect size estimates. Power is a function of sample size, the criterion of statistical significance (alpha level), and the true effect size between groups.

Focusing on the power of psychotherapy outcome studies to detect differences between treatments, Kazdin and Bass (1989) evaluated 85 psychotherapy outcome studies that included a treatment-treatment, treatment-no treatment, or a treatment-placebo comparison. Treatment groups averaged 20 subjects or less in 75% of the studies. When two treatments were compared, effect sizes fell in the small to medium range. When treatments were compared with placebo controls, effect sizes fell in the medium to large range. Only 45.3% and 28.6% of the treatment-treatment studies had adequate power to detect large effect sizes at post-test and follow-up, respectively. Yet, 82.5% of treatment-control comparisons and 90.0% of treatment-placebo comparisons had enough power to detect large effect sizes; larger effect sizes obtained when treatment is contrasted with controls. Sample sizes of 71 per group are necessary to keep power at 0.80 or in the large range and control for error rates (Kazdin and Bass, 1989).

Kazdin and Bass (1989) conclude that psychotherapy outcome studies, comparing two treatments, lack adequate power to detect differences. Conclusions about the Dodo bird hypothesis are, therefore, inconclusive. They suggest examining power in individual outcome studies to determine if studies for some orientations are weaker than others to detect treatment effects; some therapies fare worse when studied empirically because of

methodological issues including reactivity, sensitivity of outcome measures, treatment integrity, subject homogeneity, assessment conditions, therapist experience and training.

Kazdin and Bass (1989), like others, contend that the efficacy of psychotherapy, above no treatment or control has been well established; again, the more pressing issue is the interactions between which psychotherapy works best, for whom, by whom, and where. Because testing interaction effects further divides sample sizes, compensating with large enough sample sizes is paramount. Unless sample sizes are dramatically increased, fine analyses of treatments will be futile (Kazdin and Bass, 1989).

Empirically Validated and Supported Treatments

Empirically Validated Treatments, or EVT, are empirically-based specific treatments for specific psychological problems; a treatment's efficacy must be demonstrated in controlled research in which it is reasonable to conclude that benefits observed are due to the effects of the administered treatment and not to any confounding variables such as time, assessment or individual characteristics (Chambless and Hollon, 1998). EVT are designed to assist mental health practitioners by providing evidence-based data to support the choice of a psychological treatment or intervention for specific diagnoses. EVT purport to be the best treatment available under the situation.

Based on scientific, statistical data, EVT assist professionals in obtaining third-party reimbursement for services and treatment planning (Chambless, 1998). EVT can counter fiscally-driven decisions to limit mental health care by managed care. EVT success depends on their endorsement by professionals, academia, managed behavioral health care and related funding sources (Packard, 1995). Kiesler (2000) suggests that,

when evidence-based data link mental health outcomes to cost-effectiveness, concerns about access and quality of care be corrected. The National Advisory Mental Health Council(1998) concludes that adherence to consensus treatment guidelines can improve patient outcomes and promote development of new techniques with higher quality.

EVT became the focus of a Task Force established by the Division of Clinical Psychology of the APA in 1993, quickly growing in focus thereafter. Their prominence is evidenced by their inclusion in the 1996 Guidelines and Principles for Accreditation of Programs in Professional Psychology (Beidel, personal communication, March 9, 1995, in Crits-Cristoph, et. al., 1995). The scientist-practitioner model necessitates attention to the empirical basis for psychotherapeutic practice. Though most EVT are behavioral or cognitive-behavioral in nature and focus on symptom relief, they meet the goals of third-party payers of identifying problems, developing specific treatment plans, and targeting outcomes in relatively short time-spans (Calhoun, Moras, Pilkonis, & Rehm, 1998).

Chambless (1998) cautions that not all treatments have yet been reviewed and treatments not appearing on the list are not necessarily ineffective but have not been established to the satisfaction of the task force. Granello and Witmer (1997) contend that, with over 300 DSM-IV diagnosis and over 400 treatment approaches, the task of matching treatments and disorders seems monumental; designing studies to compare all possible combinations is an ominous task that will probably not be accomplished.

Inclusion on the list of 'well established' models is based on a number of criteria. A treatment 1) must be highly specified, through treatment manuals, with procedures that are clearly understood and replicable by others and where the processes and procedures of the interventions are specifically and clearly delineated, 2) validated in studies in which

the characteristics of the client samples were clearly described, 3) documented to be effective in either a) at least two group design studies of adequate statistical power demonstrating efficacy through superiority to pill, placebo, or and already established treatment, or b) a large series of single-case design studies using good experimental design and showing superiority to the same above three conditions, and d) demonstrated to be effective in reliable and valid studies by at least two different investigators.

An EVT must be superior or equivalent in efficacy to another treatment already designated as well established. The treatment manuals need to provide a clear and explicit description of the techniques and strategies involved, either in session-by-session descriptions or broad principles of phases of treatment. Attention is given to adherence to these manuals, since a lack of a treatment effect might reflect poor implementation and not ineffectiveness for the problem at hand (Chambless and Hollon, 1998).

Treatments that cannot satisfy the above criteria are labeled 'probably efficacious: 1) there are two studies showing that the treatment is more efficacious than a wait-list control group, 2) at least one study demonstrates efficacy through performance superior to pill, placebo, or an established treatment, 3) a small series of good single-case design studies, or 4) at least two studies demonstrating efficacy but flawed by heterogeneity of the client samples. All studies not meeting the criteria for either group are labeled 'experimental treatments.' (Crits-Christoph, Frank, Chambless, Brody, and Karp, 1995).

In response to critiques of the Task Force's findings, Chambless and Hollon (1998) altered their conception of EVT, replacing the term with Empirically Supported Treatments (EST), thereby avoiding the connotation that the validation process was complete and deterring policy conclusions based upon an incomplete body of knowledge.

The second difference from EVT concerns the requirement of specificity. Specificity defines a treatment as superior to pill, placebo, or another treatment because it allows greater inference about causal agency. Chambless and Hollon (1998) contend that specificity is not necessary to prove an EST's beneficial effects; a treatment is efficacious if it produces results superior to no treatment.

When a treatment proves superior to another treatment, after controlling for nonspecific confounding variables (i.e. client, psychotherapist, and process variables), then the treatment is considered specific and efficacious. This criteria is relaxed because an EST does not have to prove to be more efficacious than another treatment approach for a specific disorder (Chambless and Hollon, 1998). Packard (1995) expressed concern that replication in two independent studies is not sufficient, given issues affecting research outcomes such as geographic region, cultural differences, service settings, and demographic variables that cannot easily be controlled for through randomization.

The earliest treatment manuals from the 1960's were attempts to reduce variability between therapists in psychotherapy research, by evaluating psychotherapist adherence to the different treatment modalities under investigation (Lambert, Chiles, Kelsel, & Vermeersch, 1998). Their use became common in the 1970's, especially with group workshops that emphasized training and teaching goals (Lambert and Bergen, 1994). They are now the means to deliver EST. Manuals differ in terms of flexibility afforded a psychotherapist. Manuals offer a number of advantages: a framework for treatment, stronger internal validity of research studies, a way to train psychotherapists, clear descriptions of psychotherapeutic techniques, scales to assess competence and integrity, a

means of replicating treatments, facilitating comparison of components of treatment, and examples of appropriate applications (Lambert and Bergen, 1994).

Manuals have the potential, however, to hamper psychotherapist flexibility, neglect nonspecific factors in change, are not suited for use with integrated approaches, and do not offer means to assure psychotherapist adherence in clinical practice. Over sixty manuals are available for disorders like depression, anxiety, panic, eating disorders, personality disorders, schizophrenia, relationship problems, sex offenders, sexual dysfunction, sleep disorders, substance abuse, weight management, and social skills training. They include approaches such as cognitive-behavioral, behavioral, dynamic, interpersonal, experiential and systems orientations (Lambert, et. al., 1998).

Goldfried and Wolfe (1998) view strict adherence to treatment manuals as a research hindrance. Manuals are meant to assure treatment integrity across therapists and allow a faithful replication of the research but do not necessarily create psychotherapist equality because not all psychotherapists are equally effective or competent. Goldfried (1997) discussed the psychotherapy effectiveness studies conducted by Luborsky with 22 therapists and 7 different samples of depressed and drug addicted clients. All of the psychotherapists were trained with the same manual yet attrition rates and success rates varied across psychotherapists, highlighting the need to delineate therapist variables, such as competence and personality characteristics, which affect psychotherapy outcomes.

Goldfried and Wolfe (1998) contend that manuals are limited in terms of external validity; because of the complexity of clinical work and the need to tailor interventions to clients, most therapists do not do psychotherapy by the book. Persons and Silbershatz (1998) suggest that one of the key ingredients of effective psychotherapy may be the

therapist's ability to tailor interventions to the specific problems and needs of each client. Many manuals do not have process recommendations for handling unexpected glitches.

Standards of Care

Standards of care are minimal treatment standards agreed upon by researchers and clinicians; people in the same discipline or by a significant minority of relevant professionals. They are systematic and comprehensive approaches to treating different disorders, often borne out of efficacy and effectiveness research. They include the professional conduct as practiced by practitioners who have special knowledge and ability to diagnosis and treatment of clinical conditions (Granello & Witmer, 1997). Standards of care are increasingly used by managed behavioral health care companies, in malpractice suits and to address legal and ethical issues; courts can accept a procedure as legitimate if documented proof of its use by a substantial minority can be provided.

Beutler and Davidson (1995) note there is no set standard by which scientific validity is defined. The empirical standards are partially influenced by personal biases and beliefs and social values, independent of scientific evidence. Beutler and Davidson (1995) discuss five approaches to empirical validation. Two non-empirical approaches are face validity and consensual validity. Face validity accepts an explanation as logical in the absence of empirical verification, if it fits personal experience. The authors suggest that 40% of clinical research instruments rely on face validity rather than independent verification of reliability and validity. Consensual validity relies on expert opinion above empirical evidence; community standards against which one's practices are compared.

There are three empirical approaches to validation. Theoretical validity suggests research does not add to theoretical understanding and is of limited value. Replicability holds that an observation is valid if it is objectively observed on more than one occasion. This criteria, on which EVT and EST are based, does not assess the relative balance of positive and negative findings or define what constitutes a sufficient number of occasions. It favors simple problems and models and concrete outcomes, disallows procedures that address nonlinear, multidimensional problems and interaction effects such as fitting multiple treatments to specific problems.

Finally, in incremental validity, if a procedure does not add to a simpler, easier to understand procedure, it is rejected. Beutler and Davidson (1995) recommend the following decision rules for deciding when a procedure has achieved the scientific validity. Replicability is the most sound procedure, when tempered with face validity. The degree of replicability is a factor in considering negative findings; number of replications must be based on a proportion of positive to total studies and the use of multi-dimensional criteria and multi-level evaluation.

The field of psychotherapy research has modeled itself after psychiatry and, in particular, the gold standard Randomized Clinical Trials (RCT) of the drug companies. EVT and EST research is consistent with the Food and Drug Administration's (FDA) criteria that all active ingredients of a medication be identified. Pallak (1995) discusses the three phases of clinical trials. Phase I studies are safety studies looking for adverse events in human subjects. Phase II studies involve 30-60 subjects who have the diagnosis to be treated by the drug. Phase III studies are efficacy studies or large clinical trials often lasting one year and involving actual patients and practicing physicians.

Individuals with more than one diagnosis, comorbid diagnoses, are excluded from studies to maintain internal validity and increase the chances of relating effects to the drug (cause) under investigation. A primary component of these trials is the use of placebo or no-treatment control groups to control for confounding or external variables that might impinge on the internal validity of the study. Results focus on group norms for outcome with little attention to individual differences in the statistics produced.

Proponents and Dissenters of EVT and EST

Proponents believe a stronger scientific base for clinical practice will elevate the status of the mental health professions closer to the natural sciences. EVT and EST are a means to empirically debate managed behavioral health care restrictions on amount and quality of care by amassing data in support of treatment options (Clay, 1998, March) or creating standards and developing better treatment alternatives, to guard against potential abuses (Broskowski, 1991). With respect to a therapist's contributions to development of utilization review criteria, Kiesler (2000) states, "This means such things as developing consensually based standard treatment for specific presented problems..." (p.485).

Psychotherapists have an ethical responsibility to provide their clients with the most effective and efficient, evidence-based treatment for the problems for which they seek help (Hayes, 1995; Persons and Silberschatz, 1998; Wilson, 1995). Though operational definitions of quality care are not consensual, the burden of proof has shifted to the provider of services; therapists trained in research are at an advantage in a market concerned with developing cost-effective treatments (Broskowski, 1991). Yet, DeLeon et al. (1991) suggests that therapists are uncomfortable being accountability for the

effectiveness of their services. There is a "negative correlation between scientific evidence of the effectiveness of a treatment and their application in routine clinical practice (Wilson, 1995, p.186). Empirical evidence, through EVT and EST research, will enable practitioners to regain independence and authority position lost to managed care that began with the escalating costs of mental health care.

Proponents of EVT and EST research applaud the use of RCT and use of DSM IV diagnostic categories in assessment and outcome measures. Randomization, a hallmark of quantitative research, controls for the confounding effects in individual difference variables, balancing the effects of personal characteristic on results. Randomization allow researchers to make firmer causal inferences about a treatment's effects, above factors common across all psychotherapies. Persons (1998), a strong advocate of RCT, reminds readers that the procedure is the gold standard for research in the medical and drug fields; RCT results can direct which psychotherapies, or its parts, are superior to other psychotherapies, placebo, or no-treatment conditions. Use of DSM IV nosology allows development of a body of research based on similar definitions with standardized measures, facilitating replication of results (Chambless and Hollon, 1998).

Those practitioners and researchers who are ambivalent about EVT and EST research believe its focus on symptom reduction is less desirable than psychological growth. They also contend that experiential, dynamic, and phenomenological variables are less reliably and validly assessed by existing measures. The effects of some forms of therapy may be too complex and subtle to be objectively assessed (Weisz, et. al., 1995). Anders (1996) suggests good therapy means addressing acute episodes of distress and the

underlying causes of despair. Persons and Silbershatz (1998) contend some treatment, not included in EST or EVT, are ecologically valid and beneficial as actually practiced.

Davidson (1998) expressed concern that the mental health disciplines are not yet able to define client's problems or treatment interventions in terms meaningful enough to allow a matching between the two; rigidly matching all clients with a similar diagnosis to the same treatment approach eliminates individuality of client's needs and flexibility in treatment planning. Weisz, Donenberg, Han, & Weiss (1995) suggest that practitioner creativity to develop newer, more efficacious psychotherapies might wane because of the need to strictly adhere to existing research findings. Chambless (1998) notes the fear that therapists will be reduced to automatons who use rigid criteria to fit a treatment to all types of clients with a given diagnosis, regardless of their needs. She sees no reason that manual-based treatments cannot be altered into the best combination for particular client.

Many professionals are reacting to perceived threats to their independence; although some welcome combining EVT and EST with their treatment plans, therapists whose orientations are not behavioral or cognitive in nature fear that their access to third-party payers will be cut-off unless they endorse these treatments (Chambless, 1998). A primary area of tension concerns the art versus science debate that has plagued mental health fields for centuries (Weisz et al., 1995). Today's version of this debate is the distinction between flexible treatments and strict adherence to manualized techniques.

Efficacy research often compares a treatment with a placebo or control condition. Comparing different psychotherapies is avoided because of difficulties with using similar measures of change for different theoretical approaches. EVT and EST only prove that a treatment is superior to no-treatment or a placebo; the latter is a way to control for

common factors (Borkovec and Castonguay, 1998). In contrast to Person's (1998) view, these studies cannot conclude that one treatment is superior to another active treatment because comparing the two is not an internally valid methodology; it is impossible to hold all but one factor constant between different therapy approaches and decipher the specific agent of change. Specific causative ingredients of EVT and EST, mechanisms of change and how they occur, have also not been established. The only valid, causative conclusion is that the psychotherapy under question has been proven to cause improvement beyond chance and common factors (Borkovec and Castonguay, 1998).

Training in EVT and EST

The Boulder conference of 1950 was the first national meeting in the United States to discuss standards, and standardization, for doctoral training in psychology: licensing, certification, accreditation of programs, research and psychotherapy training. The resulting recommendations called for emphasis on research and practice; the scientist-practitioner model or Boulder model (Benjamin and Baker, 2000).

Although EVT or EST are now a requirement for clinical and didactic training programs, their use in both settings remains limited (Wilson, 1995). A survey by Crits-Christoph, Frank, Chambless, Brody, and Karp (1995) found a large percentage of psychological training programs lack any or minimal exposure to them. Crits-Christoph et al. (1995) noted 18 treatments as well established and 7 as probably efficacious at the time of their writing. The list is heavily weighted toward those treatments that are behavioral, cognitive, or some combination of the two; additionally, empirical validation has not been established for a large number of emotional and behavior disorders.

Crits-Cristoph et al. (1995) sampled 595 directors of psychological training programs and internships. Less than half of those responding provided exposure to EVT or EST in classroom instruction, practicum or internship training; over 20% surveyed indicated that their training did not meet the criteria for minimum amount of coverage. One doctoral program in five covers less than 25% of EVT or EST training. The authors speculate that, had they requested information on training to competence, the percentages would have decreased. For internships, the most supervision was offered and competency required in short-term dynamic and structural and strategic family psychotherapies.

Crits-Cristoph, et. al. (1995) speculate that emerging psychologists who are not competent to deliver EVT and EST will find it increasingly difficult to be successful and competitive in the emerging outcome-oriented health care market or meet the demands by third-party payers and policy-makers for accountability; this includes the ability to identify problems on which to focus, develop specific treatment plans, measure goals and demonstrate effective outcomes; conduct in brief psychotherapy, make accurate assessments, and request authorizations. Because efficacy studies utilize some form of training manual, detailing conceptual and theoretical understanding, specific skills to be acquired and methods for assessing trainees or therapist skill, transfer of EVT or EST knowledge into academia and internship training should be easily facilitated.

Debate continues as to whether training manuals are useful and adequately formulated. Today, more well-developed manuals exist and are comprehensive in their attention to procedures, training, sequencing of interventions, limitations and dealing with complications (Calhoun, 1998). Some professionals are concerned that protocols provide

little information for dealing with resistance and problems in the therapeutic alliance, characteristics of effective psychotherapy (Persons and Silberschatz, 1998).

Davidson (1998) suggests that strict adherence to manuals can lead to two problems, particularly with regard to training. First, EVT and EST and associated manuals rely on RCT in which group averages form the basis of statistics and guidelines. Idiographic case formulation (Persons and Silberschatz, 1998) and extensive case assessments are lost. Novice therapists might indiscriminantly apply the techniques to anyone with a given DSM-IV diagnosis. Davidson (1998) notes there are different etiologies to diagnoses; an intervention's success depends in part on applying it to those client's for whom it is appropriate. Second, innovation in clinical practice may diminish as novice therapists develop tunnel-vision based upon strict adherence to a manual. As a result, there is continual need to remain open to new, not validated approaches.

Calhoun, Moras, Pilkonis, & Rehm (1998) outline such a detailed and comprehensive training program which would sequentially address pre-doctoral, internship, post-doctoral, and continuing education training. At the pre-doctoral level, there would be didactic and experiential exposure to efficacious treatments. The authors stress the importance of faculty objectivity about EVT and EST as the primary factor determining when and how they are taught in academic settings. Davidson (1998) suggested that academicians and practitioners resist attention to EVT and EST due to long-standing allegiance to university tradition and to approaches with less empirical justification in which tenured faculty retain course teachings which may no longer be relevant or conducive to today's scientist-practitioner model (Calhoun et al., 1998).

At the internship level, more attention would be given to the scientist-practitioner interface, particularly the clinical use of EVT and EST, underlying psychological principles, a thorough understanding of those clients who would benefit from them, and training with treating comorbid disorders. This would require that practitioners and supervisors be neutral or optimistic about EVT and EST and proficient to teach them. Unfortunately, most internship sites do not have enough clients with homogenous, specific diagnoses to extensively train in EVT and EST (Calhoun et al., 1998).

At the post-doctoral level, training to competence in a number of specific EVT and EST would continue and would focus on adapting EVT and EST to unusual or treatment resistant clients. No standards exist regarding training to competence. Calhoun, et. al. (1998) suggest that those scientist-practitioners who developed EST and EVT are in a good position to develop clinical training sites. At the level of continuing education, EVT and EST dissemination appears to be difficult. Standard workshop duration is too short to competently master a treatment and opportunities for hands-on training are lacking. The substance of many workshops is often based on theoretical and professional allegiance not EVT or EST. Some psychotherapists attend workshops only to meet state requirements, with little intention of altering their therapeutic style (Wilson, 1995).

Calhoun, et. al (1998) conclude with seven recommendations or guidelines for training in EVT and EST that include video-tapes to teach central components of the treatments and common errors and for use in supervision, observer ratings to evaluate trainees' progress, group supervision to efficiently facilitate learning, supervision of a minimum seven to eight cases, and instruction for on-going evaluation of client's response to the treatment. Chambless (1998), addressing revisions to the Task Force's

initial recommendations, advocated for development of specialized training and clinical facilities that would offer superior treatments for specific diagnostic conditions.

Goldfried (1998) suggests that premature adherence to the present volume of efficacy research may negatively influence training and research. Specialized clinics would create problems such as focusing only on frequently occurring disorders, limiting training to a narrow range of disorders, and possibly creating an ethical dilemma refuse clients whose diagnosis is not one for which the therapist was trained. Calhoun, et. al. (1998) suggest that, at internship, students are developing a professional identity in what may be their final chance to receive generalist training. They recommend that room be allowed for learning approaches that presently are less supported by efficacy data.

If EVT and EST are eventually supported by managed behavioral health care payers for reimbursement purposes, the issue of who will pay for retraining existing psychotherapists remains unanswered. Weisz, et. al. (1995) suggest that insurance companies appear more concerned with cost-containment than funding such efforts. Retraining would not only involve practicing clinicians and therapists but also those professionals in academia, internships, and post-doctoral study responsible for disseminating the efficacy literature to graduate and training students.

Examples of EVT and EST

Many psychopathological and psychological problems have been examined by efficacy studies but, for some problems, no proven research exists. (Weisz, et. al., 1995) Exclusion from the list of EVT and EST does not guarantee a treatment is ineffective; it has not been sufficiently researched to the satisfaction of the Task Force (Chambless,

1998). There are over 16 existing EVT or EST. They include interventions for anxiety, panic, phobia, agoraphobia, obsessive-compulsive disorder, stress training, depression, headache, bulimia, rheumatic disease, smoking cessation, enuresis, oppositional behavior, and marital discord (Chambless, 1998); recent additions include schizophrenia, post-traumatic stress disorder, social phobia, alcohol and substance abuse and dependence (DeRubeis and Crits-Christoph, 1998). The most common diagnosable, treated disorders are depression and anxiety (Lambert & Bergen, 1994).

An example of an EVT concerns Obsessive Compulsive Disorder (OCD), the fourth most-occurring DSM-IV disorder characterized by recurrent and persistent obsessive thoughts and compulsive acts and often preceded in adults by a history of separation anxiety, resistance to change, risk aversion, magical thinking and excessive morality. The treatment of choice is behavioral and combines of exposure and response prevention techniques. (Barletta, J., Beamish, P., Patrick, M., Anderson, K., & Pappas, N., 1996; Fals-Stewart, W, 1993). A hierarchy of obsessive thoughts and compulsive acts is developed, to determine their frequency, duration and amount. There is a psychiatric assessment to rule-out any physiological or neurological disorders. Clients are repeatedly exposed to feared situations, objects, and thoughts until each can be faced without debilitating anxiety. Hierarchy items are addressed from least fearful to the most. In response prevention, critical to breaking compulsive cycles, the rituals performed to contain the anxiety triggered by anxiety-provoking situations, are prevented from materializing by gradually delaying, diminishing, or blocking the ritual.

Exposure and response prevention are often accompanied by homework assignments, modeling within sessions as well as with the participation of family

members, aversion therapy, imaginal flooding, and paradoxical intention. Drug interventions alone are effective with over 50% of clients; however, relapse upon abrupt discontinuation can go as high as 90% within the first two months (Barletta, et. al, 1996). Long-term follow-up is poor for drug treatment alone (O'Sullivan, Noshrivani, Marks, Monteiro, and Elliott, 1991, in Fals-Stewart, W., 1993).

Barletta, et. al (1996) report that, in over 50% of clients, OCD symptoms are reduced by 70-80%. Treatment is most successful when clients attend two to three times weekly for several concurrent, tightly-spaced weeks. Following an active treatment phase, the termination phase of therapy consists of bimonthly sessions over a 2-3 month period (Fals-Stewart, W., 1993). Two issues diminish treatment effectiveness: comorbid DSM-IV personality disorder diagnosis that is not treated concurrently, and attrition (25% of clients either refuse or quit behavior therapy early). Convincing clients and significant others to accept the treatment plan is stressed to maintain participation.

Homework assignments and transfer of skills to new situations, people, and events is stressed (Barletta, et. al., 1996). Fals-Stewart (1993) recommends administering standardized scales to measure subjective anxiety. Throughout and following treatment, these scale can be re-administered to provide an objective measure of progress. No efficacy studies have been conducted that examine the effectiveness of psychodynamic psychotherapy for the treatment of OCD, making it difficult for proponents of these approaches substantiate continued use of these treatments in a managed care environment (Persons and Silbershatz, 1998).

Outcome Measures

Chambless and Hollon (1998) acknowledge the need to include outcome measures that go beyond assessment of symptoms and examine the effects of treatment on general measures of functioning and quality of life. It is necessary to broaden the criteria for mental health to include global, practical measures of functioning along with the absence of symptoms (Pallak, 1995). Lambert and Bergen (1994) suggest the use of statistical significance and effect size estimates are an abstraction and recommend measures of clinically significant changes made in therapy. More relevant outcome measures are required (Kielser, 2000). Interestingly, such outcome measures are not often included in efficacy research because of the complexity involved in defining what levels of change are desirable as well as what areas of functioning should be assessed.

The National Advisory Mental Health Council (1998) concluded that consensual quality measures must be developed and tested for reliability and validity as well as adjusted for comorbid, concurrent disorders. The council suggested beginning to gather baseline data in initial clinical assessments of all patients, including longitudinal assessment at 6 and 12 months post-treatment, assessing functioning along multiple domains, and linking outcome data with managed behavioral health care cost and utilization data to provide a comprehensive picture of the effects of increased access to care on measures of cost and quality of that same care.

Outcome data would be gathered from both clients and providers. Follow-up is also given greater weight; determining the stability of treatment effects, whether treatments redress a person's propensity for risk with certain patterns and issues, and whether clients obtain stable skills to enable better coping with enduring vulnerability.

Chambless and Hollon (1998) acknowledge the issue of delayed treatment effects and the need for longer-term follow-up in studies on treatment efficacy.

Kirk Schneider (1999) differentiates between treatments and relationships: techniques applied to measurable, well-defined symptoms versus addressing complex life issues (e.g. purpose and values) as well as symptoms, respectively. Schneider (1999) suggests that the 'romantic' approaches to psychotherapy, i.e. phenomenological, psychoanalytical, psychodynamic, client-centered, case studies, humanistic, need to be assessed and evaluated by methods appropriate to their aims. He suggests conventional methods for measuring outcome focus more on quantifiable dimensions of therapy, manualization, DSM-IV diagnoses, selective samples and oversimplified objectives.

The romantic approaches are at a disadvantage when psychotherapy outcome studies are evaluating their efficacy. Approaches such as controlled single case designs are amenable to qualitative analysis if one accepts the inquiry as a valid approach to scientific study. Though it contrasts sharply with quantitative approaches to science within which RCT fall, there are strategies to guard against selection bias and problems with data interpretation through the use of multiple sources of information.

A May 1999 article in the APA Monitor stressed this point. An APA statistics task force was preparing to release 20 recommendations for the analysis and reporting of research data that confirmed the validity of a variety of techniques. Along with suggestions that research methodologies, statistics and techniques be more clearly articulated to facilitate replication of findings and generalizability, attention is given to problems created by over-reliance on significance testing as the sole basis for research

conclusions; an approach that led to publication of many studies that reached significance and rejection of potentially important studies that did not.

Packard (1995) points out the advantages of using a moderately effective treatment with smaller attrition than a highly efficacious treatment with high dropout rates. Lunnen and Ogles (1998) discuss two fundamental problems with use of statistical significance as an index of client change: individual information is lost when group means are the focus and measures of change bear little relevance to actual changes.

The Quality of Life Inventory (QOLI) is an example of a broad measure of life satisfaction that can complement symptom-oriented measures of psychological functioning when defining mental health and adjustment. Frisch, Cornell, Villanueva, & Retzlaff (1992) conducted a psychometric evaluation of the QOLI. They define quality of life as the degree to which a person's most important needs, goals, and wishes have been fulfilled. The concept is purportedly related to a phenomenological form of depression. The QOLI focuses on subjectivity and measures 17 domains or areas of life including health, self-regard, standard of living, work, recreation, learning, creativity, social service, love relationship, friendships, relationships, home, and community; each domain is weighted according to its relative importance for the individual. The QOLI is based on cognitive mapping studies and is applicable to clinical and non-clinical populations.

Frisch et. al. (1992) administered the inventory to several inpatient and outpatient groups with mental health and substance disorders and non-clinical populations. The QOLI was compared with The Life Satisfaction Interview, the Beck Depression Inventory (BDI), Millon Clinical Multi-axial Inventory-II (MCMI-II), and Symptom Checklist-90-R (SC-90-R). A peer measure was included to provide an additional perspective. ANOVA

results indicated that the QOLI was internally consistent and stable over a one to two month interval. Scores were significantly correlated with seven measures of well-being and life satisfaction and negatively correlated with scores of depression, anxiety, and general psychopathology, validating the constructs independence from such measures.

Frisch et. al. (1992) stress the advantages of using the psychometrically validated measure in psychotherapy practice and research. They suggest subjective well-being is a primary criterion of positive outcome from the client's perspective. The QOLI allows for comparison of different and diverse therapies that, despite theoretical differences, all aim at increasing subjective well-being. Use of a common measure would facilitate meta-analyses and direct comparison of therapies. Because client dissatisfaction within the 17 measured domains can be identified, exploring client's perceived blocks to satisfaction could assist in treatment planning and goal setting and exploration of the situations that create and maintain negative symptoms. When supplemented with standardized outcome measures of behavior, interpersonal and social performance from others' perspectives, assessment of therapy outcome could be a more complete and clinically useful venture.

Lunnen and Ogles (1998, in Lambert and Cattini-Thompson, 1998) also stress the need to use multiple perspectives when evaluating client change in therapy. Their study using Jacobson and Truax's reliable change index, a measure of the clinical significance of change that evaluates progress and dysfunctional symptoms on a continuum. The technique calculates two statistical indexes: a cut-off point between normal and dysfunctional samples and an evaluation of the reliability of the change score. Together, they offer specific guidelines for interpreting client change.

Clients were placed into one of three post-treatment groups, improvers, no changers and deteriorators, based on scores on the Outcome Questionnaire-45 (OQ-45), a measure of client progress in therapy administered throughout and after treatment. The OQ-45 measures subjective discomfort, interpersonal relationships, and social role performance. Significant others and psychotherapist's perceptions of client change were also measured. A total of three perspectives of change were gathered under the belief that multiple perspectives would enhance the generalizability of the findings.

No significant differences were found using ANOVA between the criterion groups of improvers, no changers, and deteriorators on a number of confounding variables. The results indicated that clients who improved were differentiated from the other groups in perceiving more symptomatic change and a stronger therapeutic alliance; psychotherapist's ratings of these two measures were similar. The results suggest a consistent relationship between therapeutic alliance and outcome. Satisfaction with psychotherapy did not differentiate improvers from the other groups. Lunnen and Ogles (1998, in Lambert and Cattini-Thompson, 1998) suggest that future research pair these subjective measures of outcome with more objective measures, thereby validating or disconfirming the relevance of using clinical significance methodologies.

Lambert and Cattini-Thompson (1998) stress the need to use multiple assessment methods because the instruments and methods of for diagnostic purposes and treatment planning are not suitable for the purposes of measuring client change. The authors offer a number of suggestions for choosing assessment tools to measure psychotherapy outcome. First, the content area of the instrument should cover three broad areas: the subjective state of the, intimate relationships or interpersonal functioning, and role performance.

They note, "Empirically, the results of outcome studies are more impressive when content is measured across all three content areas" (p.23). Second, change should be measured from the multiple viewpoints thereby counterbalancing of the fact that measurement is strongly affected by the biases of the person providing the data.

Third, because methods of collecting outcome data can affect the final index of change, it is recommended that four categories of change be included: global ratings such as client satisfaction, descriptions of specific symptoms, observation of behaviors, and physiological measures. This would counterbalance the tendency for specific measurements to yield more objective reports because they focus on specific symptoms. In efficacy studies, behavioral approaches produce larger effect sizes than non-behavioral ones because the measures are specific to the problems being addressed and tend to produce larger change scores. Fourth, standardized assessment tools must supplement subjective measures to enhance the validity of measures of change with instruments whose psychometric properties have been established. The ideal approach would include both statistically significant and clinically useful indexes of client change.

Seligman (1995) makes a strong argument against the use of standards of care extracted from EVT research as the standard by which to measure treatments. In an article commenting on the Consumer Reports study of psychotherapy's effectiveness, the author points out that in efficacy studies, treatment is delivered under tightly controlled conditions in a laboratory setting where subjects are carefully screened and sensitivity is maximized. These conditions may not provide the best indication of which therapies and therapists are most productive because of the artificial nature of the conditions. Weisz, et. al. (1995) reiterated these concerns with regard to child therapy outcome studies.

The Consumer Reports study emerged from their annual questionnaire regarding product use and satisfaction. Of the 100 questions, over 25 were related to therapy for anyone who had seen or consulted with a psychologist, psychiatrist, social worker, marriage counselor, or family medical doctor for problems over the past three years. Consumer Reports measured a number of satisfaction, personal, and therapy issues under the premise that a unidimensional outcome measure was insufficient to understanding therapy's effects; the study looked at specific problems and symptoms, satisfaction, and global measures of improvement which included work, social and intrapsychic domains.

The results were as follows. Treatment by a mental health professional was effective for 87% of respondents. Second, long-term psychotherapy produced more improvement than short-term therapy; the longer the therapy, the more improvement reported. Third, psychologists, psychiatrists, and social workers fared better than marriage counselors and substantially better than family doctors. Fourth, active clients, who chose their psychotherapist, treatment type and length, fared better than passive recipients; individuals whose choices were limited by their insurance companies.

Seligman (1995) notes a number of the methodological flaws in this study that used a survey method. Among them is included sampling bias, the use of self-report, lack of control groups, use of retrospective accounts, nonrandom assignment, and the use of inadequate outcome measures (exclusion of standardized questionnaires). However, the author highlights an important virtue inherent in all of these objections; the survey and this method measure the effectiveness of psychotherapy as it is actually practiced in the field. He suggests that the efficacy study used in EVT and EST research is artificial.

Efficacy research often eliminates long-term dynamic psychotherapies, some family therapies, and eclectic therapies; they are too cumbersome to test because of the myriad of independent and dependent variables or the cost of conducting long-term research. Seligman (1995) suggests considering this issue when evaluating the definitive conclusions of EVT and EST research and superiority of the researched treatments. According to Seligman (1995), five characteristics of psychotherapy as it is conducted in the field are noteworthy and important to client improvement and satisfaction. First, psychotherapy is not of the fixed duration seen in efficacy studies. Second, therapy is self-correcting; when a particular modality or technique is ineffective, a psychotherapist tries another until one is found that suits a person's psychological make-up.

Third, psychotherapy clients are active shoppers and participants; they work with a professional whose approach and personality are congruent with their needs. Fourth, unlike the controlled study subject who is carefully screened for a single, clearly-delineated DSM-IV diagnosis, actual clients have comorbid problems affecting multiple areas of their lives. Finally, actual psychotherapy focuses on improvement in multiple areas of functioning; specific problems as well as general well-being and quality of life. The Consumer Reports survey results, though less statistically stringent than efficacy research, are realistic measures of therapy's effectiveness as it is actually practiced.

Persons and Silberschatz (1998) reinforces these points by stressing the heterogeneous diagnoses of clients, concerns with issues others than symptoms contained in DSM-IV diagnoses, and individualized treatment planning. Wilson (1995) discusses differences between research studies and clinical practice along several dimensions:

comorbid, complex target disorders, selected versus recruited subjects, the training and supervision of therapists in research settings, and manualized therapy interventions.

Seligman (1995) argues for continued use of surveys when combined with the methodological virtues of traditional outcome research: use of control groups to account for confounding variables for clients, psychotherapists and therapeutic relationship, use of well-normed questionnaires to better quantify results across time, and blind diagnostic work-ups to add a multiple perspective to self-report. Seligman (1995) guards lay people and professionals alike against blind acceptance of the results of efficacy and EVT research by focusing on the fact that consumers of psychotherapy report better results when treatment is of longer duration or of a duration chosen by the individual client; long-term dynamic, family and eclectic psychotherapies cannot be ruled out as ineffective when they have not been adequately researched.

Mintz, Drake, and Crits-Christoph (1996) agree with Seligman (1995) that efficacy studies need to be transported into effectiveness studies to prove clinical utility and what works in the field. Meta-analysis not based on such studies is of limited value. The authors point out that, 30 years ago, studies of individuals with mixed problems, with unprescribed treatments and varied measurement were typical but have been replaced by clinical trials aimed at establishing specificity of treatment for particular disorders. The authors argue for the use of quasi-experiments that retain the rigor of efficacy studies: randomization, clear treatment procedures, blind ratings, inclusion-exclusion criteria, operationally defined outcomes, and most importantly, rigorous control groups. Blind acceptance of the method in the Consumer Reports (1995) study would be a setback for the field of psychotherapy research (Mintz, 1996).

Other authors believe that the RCT or efficacy study can answer the questions of effectiveness studies without the interpretative ambiguity involved in the latter; they also argue that statistical significance can point to clinical utility in a well designed study. In response to the Consumer's Report study (1995), Jacobson and Christensen (1996) operationalize the distinction between efficacy and effectiveness studies as follows: the former is concerned with establishing the existence of an effect while the goal of the latter is to establish the generalizability, feasibility, and cost-effectiveness of a psychotherapeutic treatment, given its efficacy.

Jacobson and Christensen believe Consumer Reports (1995) study results cannot be accepted as valid because of the following critical issues. First, retrospective studies are inaccurate and contaminated by the passage of time; their data may not be reliable due to demand characteristics or memory distortions. Second, sampling biases could explain the reported superiority of long-term therapy and the linear relationship between time in therapy and positive change; the longer people stay in therapy, the greater the chance for uncontrolled or unexamined factors to produce improvement; additional positive changes may not be due to active treatment ingredients alone.

Third, Jacobson and Christensen (1996) point out there is no substitute for the lack of a control group, making it possible that factors other than therapy could account for positive outcomes. Fourth, the dependent measures employed in the study were unreliable, measuring little more than consumer satisfaction which may not be correlated with symptom reduction or changes in general functioning. The study did not address the question of which therapies led to improvement to which problems.

Jacobson and Christensen (1996) conclude that the Consumer Reports (1995) study could have been more informative and valid if it were a prospective study that used standardized measurement techniques from multiple perspectives. They argue that the five main propositions of the Consumer Reports (1995) study could be answered by efficacy studies: psychotherapy as practiced in the real world is not of fixed duration, is self-correcting (a therapist changes course when needed and does not rigidly adhere to a treatment manual), clients are active shoppers, with multiple problems, and psychotherapy is concerned with general functioning as well as symptom rectification.

It is of concern is that the efficacy literature has not addressed many of these variables in research. Efficacy trials consist of a fixed number of standardized treatment sessions, an average of 12, in a controlled setting, with carefully screened subjects with one diagnosis, limited therapist flexibility in treatment implementation, and limited attention to process variables. Efficacy studies, as Jacobson and Christensen (1996) have pointed out, have begun to expand dependent measures to include measurement of global functioning, not just symptom rectification, thereby correcting for the design error of measurement specificity. The authors recommend that efficacy trials use component analysis to break down treatments and examine processes and mechanisms of change.

Newman and Tejada (1996) also agree with Seligman (1995) that effectiveness studies combined with efficacy research are needed to inform the major stakeholders in the mental health community about treatment utility. The stakeholders are the client, the practitioner, the insurance carrier, and the policy-maker. Treatment research conclusion must be useful to the aims of each. The authors offer recommendations to accomplish these goals. First, research must be guided by the goal of providing effectiveness,

efficacy, and cost-effectiveness information: RCT in the early stages of development, to refine technique and safety, followed by effectiveness information about who is best served by the intervention, by whom and in what context.

Second, the effectiveness portion of the research could examine the moderator variables or common factors considered important in psychotherapy outcome. Third, Newman and Tejeda (1996) advocate for variable studies not fixed in duration or dosage, so that the type and amount of effort needed to attain specific levels of outcome can be understood. Such information would also supply cost-effectiveness data to support decisions to allocate resources. Fourth, researchers need to communicate their findings in practical terms, useful to consumers, therapists, managed care companies, and policy-makers, with outcome measures relevant to all so that the information can impact on the policies of managed behavioral health care organizations.

Wilson (1995) argues for the consideration of the following standards when evaluating the effectiveness of any psychological intervention: acceptability to clients, attrition rates, clinical effectiveness based on normed and relevant measures of change, speed of action, durability of the effects, the breadth of effects, cost-effectiveness, and the ease with which the treatment is disseminated and taught. He argues for empirical study of the synergistic model of interaction of two or more psychotherapies; studying the interaction effects when effective components of different therapies are combined; an empirically validated approach to eclecticism, akin to the scientist-practitioner model.

The primary debate is between efficacy and effectiveness research. The former, EVT or EST research, is heavily weighed toward a focus on internal validity and is successful in achieving this form of control; whether the design and methodology are

scientifically sound, power is sufficient to detect significant effect sizes, and confounding or contaminating variables are controlled. Effectiveness research is primarily concerned with clinical utility or external validity; whether or not findings from the study can be generalized to the real world and psychotherapy as it is actually conducted. It may turn out that the results of efficacy studies are more interesting to the research scientist than they are useful for practitioners in the clinical fields.

Persons and Silberschatz (1998) points out that many psychotherapists are not impacted by efficacy research because its methods and findings do not address the practical issues and concerns of their clients: presenting concerns, goals sought, impediments from these goals, and the most hopeful treatments. EVT and EST address specific techniques for specific problems, useless to real clients who enter psychotherapy with multiple problems and concerns about daily living and quality of life. There is a lack of attention to the variables that supersede techniques in most effectively helping individuals. By attending to internally valid research, ecological validity is sacrificed.

Goldfried and Wolfe (1998), in their critique of efficacy research, also offer suggestions for improving the clinical utility of such studies. They stress that, should insurance companies begin to use the information derived from EVT and EST research to certify type and length of treatment, the existing gap between research and practice will be closed by outsiders to the psychotherapy field. Unlike Seligman (1995), these authors applaud the use of randomization in controlled research for protecting internal validity and against bias through selective assignment of participants to treatment conditions, assuring that individual characteristics will balance out across conditions.

However, Goldfried and Wolfe (1998) note a problem with how randomization is currently employed in efficacy studies; focusing on DSM IV diagnostic criteria for assigning subjects to conditions as well as measuring outcome. There is heterogeneity in many of the DSM IV categories and not all persons given a particular diagnosis are similar on all traits or personal attributes which may be important to therapy length and a positive psychotherapy outcome. Goldfried and Wolfe (1998) use depression as an example; it may have different etiologies necessitating different focus in treatment.

Without controlling for these subject characteristics, within group variance is created and the effects of treatment interventions are minimized; it would be difficult to determine the specifics of why a treatment worked for some individuals but not others. The focus on DSM IV diagnoses and symptoms can also constrain how problems are conceptualized and what questions are asked. Symptom reduction is overemphasized and little attention is given to individual determinants of functional cause and effect. Goldfried and Wolfe (1998) highlight the negative implications of studies with fixed treatment sessions, often driven by financial and time constraints, because the length of the intervention may be insufficient to deal with the clinical problem.

Goldfried and Wolfe's (1998) final criticism of efficacy research concerns the use of theoretically pure therapies. Eclecticism is presently the theoretical model of choice for many practicing psychotherapists. It appears there is a consensus of clinical impression that this approach produces the best clinical results by allowing practitioners to tailor specific interventions and process procedures to each client's personality and needs. But, theoretically complex models are much less empirically researched because of their complexity, the difficulty they pose for methodology and creating manuals.

An issue that has gained importance in recent years concerns the use of statistical significance testing to draw conclusions in psychotherapy outcome research because the technique may fail to illuminate significant relationships due to any number of study design flaws that affect the ability to find an effect that is present: sample size, alpha and beta levels, methodology characteristics, and treatment variables. Newman and Tejada (1996) suggest the use of the effect size estimate, as used in meta-analysis, to overcome some of these obstacles, especially the small sample sizes in psychotherapy research.

Ethical Principles of Psychotherapy

The mental health and human service disciplines have guidelines detailing minimally acceptable standards for behaviors with clients or patients (American Counseling Association, 1997; American Nurses Publishing, 1985; American Psychiatric Association, 1998; American Psychological Association, 1992; National Association of Social Workers, 1998). A number of the addressed issues are relevant when ethical and legal liability is considered in mental health treatment.

A study by the New Jersey Psychological Association (NJPA) found that pressure from managed-care companies to compromise ethical principles was a great concern to practicing psychologists; unfortunately, the data did not address specific ethical concerns or their resolution (Rothbaum, Bernstein, Haller, Phelps, and Kohout, 1998). A study by the APA (1998) found that 68% of independent practitioners expressed concern about the ethical dilemmas created by managed-care.

Murphy et. al., (1998) surveyed 442 independent psychotherapists about the impact of managed-care on professional ethics. Two quality care variables were of

primary concern to over 80% of psychotherapists surveyed: loss of control over treatment decisions and capitation or limits on number of session. Two percent of psychotherapists viewed managed behavioral health care as a positive change for insurance. Loss of referent power can increase a therapist's sense of ineffectiveness to enact change (Chodoff, 1996). Murphy et al. (1998) also found that most therapists had not terminated a client as a consequence of coverage denial: 86% reduced their fees and 69% treated clients pro-bono. But, 44% referred clients and 27% terminated treatment after coverage denials. Psychotherapists admitted to refusing to enter treatment when clients have diagnoses they knew would not be reimbursed by managed care.

Murphy et al. (1998) found that 58% of respondents believed managed behavioral health care engendered dilemmas that were not addressed by the APA Code of Ethics; unfortunately, the survey did not ask respondents to specify those concerns. Seventy-five percent of respondents felt that managed behavioral health care utilization review compromised client confidentiality; 63% felt client information could be used to harm the client. Murphy, et. Al. (1998) concluded that "There was a general acknowledgment of the clinician's responsibility to advocate on behalf of the care he or she assesses the patient needs. If that advocacy is unsuccessful, most clinician's work with the patient to arrive at a compromise solution consistent with the patient's needs" (p.51).

Hoyt and Budman (1996), proponents of managed care, believe that psychotherapists antagonisms toward managed care are not fueled by concern for client well-being; they believe the primary motivating factors are money and theoretical background. They write, "While cloaked in concerns about quality of care and other ethical issues, these reactions often seem to be expressions of psychological states of fear

and loathing fueled by perceived and veridical threats to some practitioner' theoretical biases, clinical competencies, and continued standard of income" (p.121).

The following material addresses ethical issues and ethical standards for psychotherapist's behavior in counseling, nursing, social work, psychology, and psychiatry. A number of ethical issues relevant to psychotherapy in a managed behavioral health care insurance environment will be addressed: self-determination and freedom of choice, confidentiality and dual-relationships, abandonment and termination, trust and honesty, informed consent, competence, and social change and scientific advances.

Psychotherapists are foremost dedicated to the well-being and protection of the clients they service. Self-determination involves assisting clients with identifying and clarifying personal goals for therapy. Clients are active partners in determining treatment issues and collaborating to develop treatment plans that offer reasonable promise of success and are consistent with the abilities and circumstances of clients. The fields of counseling, nursing, and social work recognize the need to involve clients or patients in the planning and implementation of their own health care and have the right to determine what will be done with their own person (American Counseling Association, 1997; American Nurses Publishing, 1985; American Psychiatric Association, 1998; American Psychological Association, 1992; National Association of Social Workers, 1998).

Miller (1996) and Shore (1996) believe a client's self determination and freedom of choice are restricted when managed behavioral health care insurers limit the psychotherapist or provider one chooses and how long the psychotherapeutic relationship is maintained. Self-determination and freedom of choice are important components for building a constructive psychotherapeutic relationship and fostering client independence

(Austad, Hunter, & Morgan, 1998; Bilynsky and Vernaglia, 1998). Knapp (1996) believes that many clients have their treatment disrupted when provider panels are changed.

Karen Shore (in Blanck and DeLeon, 1996) considers managed behavioral health care to be an immoral system that deprives clients of three basic rights: choice, privacy, and decision-making. Sank (1997) points out that the time constraints of managed behavioral health care can force clients into counter-therapeutic, premature disclosures, required by the insurance company for approval of continued care, that compromise the essence and integrity of the psychotherapeutic process.

Sperry and Prosen (1998) believe psychotherapy under managed behavioral health care has altered the process for client and psychotherapist. They note, "The more active the process, the more likely therapeutic roles and boundary issues will be affected. Greater activity and engender 'intrusion' by the therapist into the life of the patient with suggestions and advice that may be inappropriate in nature and timing. In the hands of a therapist with limited training and experience these specialized techniques may have untoward effects" (p.59). In contrast, Chodoff (1996) highlights a potential benefit deriving from the changes fostered by managed behavioral health care; specifically, psychotherapy has moved from a paternalistic process to a contractual relationship where practitioners are held accountable for incompetent and inappropriate behavior.

Confidentiality is the cornerstone of the therapy relationship. Professionals are ethically mandated to safeguard client confidences at all times, except when life or property is in danger (American Counseling Association, 1997; American Nurses Publishing, 1985; American Psychiatric Association, 1998; American Psychological Association, 1992; National Association of Social Workers, 1998). The Ethical Principles

of Psychologists and Code of Conduct 5.02 and 5.03 states respectively, "Psychologists have a primary obligation and take reasonable precautions to respect the confidentiality rights of those with whom they work or consult..." and "In order to minimize intrusions on privacy, psychologists include in written and oral reports, consultations, and the like, only information germane to the purpose for which the communication is made" (American Psychological Association, 1992, p.10).

Disclosures without client consent are made only "to obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose" (American Psychological Association, 1992, p.10). The disclosure of limited information is applicable to only the minimum information necessary to obtain approval to initiate and continue services with respect to outside parties or third-party payers.

The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry of the American Psychiatric Association (1998), recognizes the uniqueness of doctor-patient relationship. It states, "Confidentiality is essential to psychiatric treatment ...Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must be circumspect in the information that he/she chooses to disclose to others about a patient. The welfare of the patient must be a continuing consideration" (p.5-6). In a court of law, a psychiatrist may dissent from revealing privileged client to maintain trust in the therapy relationship. Sank (1997) contends that "effective psychotherapy depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. The review intrudes a third party into the consultation...serves to weaken the special bond in therapy that depends on absolute confidentiality" (p.549).

Social workers and counselors are similarly prudent to respect client confidentiality. Social workers are advised to "disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed" (National Association of Social Workers, 1996, p.10). For nurses, confidentiality "ensures the client's right to privacy; legally, it protects the client against unlawful invasion of privacy" (American Nurses Publishing, 1985, p. 4). Similarly, the American Counseling Association (1997) recommends that "Before sharing information, counselors make efforts to ensure that there are defined policies in other agencies serving the counselor's clients that effectively protect the confidentiality of information" (p. 4).

Today, greater attention is given to maintaining confidentiality of information transmitted with technologically advanced record-keeping mediums including computers, electronic mail, facsimile machines, telephones, and telephone answering machines (American Psychological Association, 1992; National Association of Social Workers, 1998). Mental health professionals are reluctant to use these technological devices used by managed-care to maintain and discuss clients. Privacy from other managed care employees and safeguarding information against hackers cannot be guaranteed. Sabin (1997) recommends developing standards for how much information an insurer needs, who can access it, how it will be secured, and how long it will be retained.

A 1995 proposed bill, the "Medical Records Confidentiality Act of 1995;" sought to make disclosure of client databases without their knowledge or consent legal (Pipal, 1996). Bilynsky and Vernaglia (1998) address this stating, "There are often many people who have access to confidential records, therefore, there is an increased risk for breaches

of confidentiality...there is an increased risk of violating the legal and civil rights of the client" (p.61). Hoyt and Budman (1996) believe that practitioner's concerns about client confidentiality stems from managed care insurers using client information to limit provider payments; they believe the issue was of limited concern under liberal indemnity insurance plans where clinicians had no difficulty submitting diagnoses and claims.

Sank (1997) and Fisher and Younggren (1997) note that psychotherapists are questioning ethics boards about how much client information can be disclosed and whether full compliance, beyond basic information about diagnosis and treatment plan, may violate ethical standards; therapists are seeking clearer guidelines about depth and breadth of information reviewers can ethically and legally request to authorize treatment. The conflicts between the demand for absolute privacy of client information and the need to obtain approval for continued care, so as to maximally service clients, create a triangle between psychotherapists, clients and, the managed behavioral health care companies.

Shore (1996) points out that psychotherapists must competitively market themselves to maintain referrals from managed care plans. She adds, "Are you afraid to speak out publicly for fear you will be ejected from networks and be unable to earn a living?" (p.71). Therapists must choose between obligations to clients and the insurers from which the psychotherapist receives remuneration (Chodoff, 1996). A triangle is created where a dyad once existed (Bilynsky and Vernaglia, 1998; Pipal, 1995). The ethical obligation to put the client first is affected by the inclusion of a third-party into the psychotherapy relationship; at times, the psychotherapist becomes more aligned with the managed behavioral health care organization to keep their practices afloat.

Shapiro (1996) believes the power and influence of the managed behavioral health care company who makes the referral is enough to alter the course of treatment for non-clinical reasons because the triangle created with managed care interferes with the trust and privacy necessary to enact psychological and behavioral change. Bilynsky and Vernaglia (1998) state that the psychotherapist "may feel forced between the dual demands of patient care and managed-care policies, a position that may compromise the unilateral dedication of psychologists to their clients" (p.55). They suggest that, before contracting with a managed behavioral health care insurer, psychotherapists know their own and their client's rights within the particular managed behavioral health care system and inform clients at the onset of treatment about the limits of confidentiality.

Many psychotherapy interventions rest upon, and stem from, an atmosphere of trust in the therapy relationship. It is the cornerstone of the referent power given to the professional (Austad, et.al., 1998; Yalom, 1985) and facilitates processing the emotional and personal information clients bring to therapy (American Counseling Association, 1997; American Psychiatric Association, 1998; American Psychological Association, 1992). The therapy relationship has been empirically established as a vital factor in effective treatment (Lambert and Bergen, 1994). Trust in the relationship can be affected when treatment plan discrepancies exist between therapists and insurance companies. Psychotherapists are increasingly aware of the need to inform clients of possible restrictions with treatment duration, before misconceptions develop, but express concern that doing so may prevent clients from fully disclosing out of fear that sensitive material will only be temporarily addressed (Pipal, 1995).

Honesty can be affected when psychotherapists, working within the confines of managed care, are required to adhere to time-limited or short-term psychotherapy; these approaches are not viewed as clinically optimal but are preferred by a managed behavioral health care company. Gag clauses prevent psychotherapists from disclosing professional opinions against these treatment approaches. They may conflict with the APA ethical principle of integrity: "In describing or reporting their qualifications, services, products, fees, research, or teaching, they do not make statements that are false, misleading, or deceptive (p.3). If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation" (American Psychological Association, 1992, p. 5)

Psychotherapists are ethically obligated to avoid abandoning clients and arrange for continuity of care when termination occurs but further treatment is warranted. APA Standard 4.09 states "Psychologists do not abandon patients or clients...Prior to termination for whatever reason...the psychologist discusses the patient's or client's views and needs, provides appropriate pre-termination counseling, suggests alternative service providers as appropriate, and takes other reasonable steps to facilitate transfer of responsibility to another provider if the patient or client needs one immediately" (American Psychological Association, 1992, p.10). The American Counseling Association (1997), American Psychiatric Association (1998), National Association of Social Workers (1996), and American Nurses Association (1985) have similar ethical directives to protect client safety, avoid abandoning clients still in need of services, and make appropriate arrangements for continuation of services when necessary.

Moldawsky (1996) hypothesizes that treatment termination, directed by insurance carrier, are based upon a cost-containment motivation not concern for quality care. If treatment approval cannot be obtained, either because the managed behavioral health care company does not consider the treatment necessary or because ethics have dictated that the psychotherapist withhold a client's personal information, responsibility for the client lies with the treating clinician, ethically and legally (Austad, et.al., 1998; Bilynsky and Vernaglia, 1998; Giles and Marafiote 1998).

Legally, psychotherapists maintain responsibility for continuing treatment, especially in cases where personal or community safety is at risk, even if an insurer declines to pay for further services (American Counseling Association, 1997; American Nurses Association, 1985; American Psychiatric Association, 1998; American Psychological Association, 1992; Keith-Spiegel & Koocher, 1985; National Association of Social Workers, 1996). Currently, the legal system does not hold the insurer responsible for the client after treatment denial; nor do the ethical codes of conduct protect psychotherapists from legal prosecution.

Involvement with managed behavioral health care companies can complicate the ethics of abandonment when continuation of treatment after insurance denial means loss of income for the psychotherapist who is legally obligated to provide for treatment for the individual. Critics of managed behavioral health care argue that provider autonomy is gone while liability has increased; proponents of managed care argue that their practices are no different than fee-for-service providers who abandon client's when finances run out (Austad, et.al, 1998). Sperry and Prosen (1998) note the arbitrariness of session

authorization and termination while rapport is still being established. A catch-22 situation develops for the psychotherapist between helping the client and making a living.

Miller (1996) believes that clients have the right to know about alternative forms of and directions for treatment, especially if desired results have not been achieved at the time of termination and particularly if the psychotherapist who is caught between the dual roles of providing clinical care and implementing insurance company treatment rationing policies. Pipal (1995) hypothesizes that psychotherapists are inclined to create diagnoses where none exists or over-diagnose clients to facilitate authorization and third-party payment. This is viewed as grounds for malpractice and concern exists that the data could be used against clients seeking insurance, employment or political office.

Confidentiality can conflict with the need to disclose detailed personal information to third-party payers. Clients agree to enter, continue, or end treatment only after given all pertinent information regarding procedures and decisions (American Counseling Association, 1997; American Psychiatric Association, 1998; American Psychological Association, 1992; National Association of Social Workers, 1996). APA ethics guidelines 4.01 and 4.02 state, "Psychologists discuss with clients or patients as early as is feasible in the therapeutic relationship appropriate issues, such as the nature and anticipated course of therapy, fees, and confidentiality...informed consent generally implies that the person...has been informed of significant information regarding the procedure..." (American Psychological Association, 1992, p.9).

Psychotherapists are obligated to inform clients of limitations of services because of requirements of third-party payer and relevant costs. It would be unethical to withhold information that clients could use to make informed treatment decisions, including other

options. The American Counseling Association (1997) created a provision for the triangle created with managed behavioral health care insurers around issues of confidentiality. They state, "When counselors work as subcontractors for counseling services for a third party, they have a duty to inform clients of the limitations of confidentiality that the organization may place on counselors in providing counseling services to clients. The limits of such confidentiality ordinarily are discussed as part of the intake session" (p.6).

Informed consent implies knowledge about limitations on monetary and session coverage. Giles and Marafiote (1998) question the ethics of gag clauses which prohibit psychotherapists from disclosing financial arrangements with clients. These authors advocate for client awareness of financial issues, treatment limitations, and issues related to clinical outcome before committing to psychotherapy. Miller (1996) notes, at the beginning of therapy, therapists must discuss with clients the nature of their relationship with insurers or other third parties important for informed consent.

Cummings, Budman, and Thomas (1998) argue that disclosing information about these issues is irrelevant for treatment and detracts from the therapy relationship and endeavor. Acknowledging the dual relationship with insurers, Cummings et al.(1998) argue against disclosure of this information, believing that fear of contaminating and hindering the therapy relationship is based on psychoanalytic principles which may have outlived their usefulness. They state, "How much of this reflects concern for the patient and how much is practitioner self-interest. How much of this will undermine the therapy by destroying the patient's confidence in the process. Disclosure is a complex set of ethical and psychotherapeutic issues that if handled simplistically, may ultimately violate the most important therapeutic responsibility of all: the welfare of the patient" (p.467).

In contrast, Fisher and Younggren (1997) direct communication of these issues engendered by managed behavioral health care as a benefit to clients who can now make their explicit needs and goals known to the psychotherapist and who can receive answers to questions regarding treatment approaches and services to be offered. Clients can also be informed about the type of treatment that can feasibly be offered within the confines of the limits to the number of sessions a client's insurance carrier will authorize.

The research community's focus on EVT and EST brings issues of ethical competence to the forefront. Psychotherapists are advised against working outside the boundaries of their competence, whether this is defined as a treatment technique, modality of treatment, or with specific populations; employing techniques to which one is new should only come after engaging in appropriate study, training, consultation, and supervision (American Counseling Association, 1997; American Nurses Association, 1985; American Psychiatric Association, 1998; American Psychological Association, 1992; National Association of Social Workers, 1996).

APA ethical standard 1.04 states, "Psychologists provide services, teach, and conduct research only within the boundaries of their competence (and) "in new areas or involving new techniques only after first undertaking appropriate study, training, supervision, and/or consultation from persons who are competent in those areas or techniques" (American Psychological Association, 1992, p.4). Concern exists that practitioners are practicing outside the boundaries of their competence when required to offer short-term, time-limited psychotherapy for which they are not trained or which is not clinically indicated. Bilynsky and Vernaglia state, "Regardless of the HMO's position, practitioners must recognize their own limitations and only provide services that

they are trained and skilled to perform...this principle may become compromised if psychologists are asked to perform duties for which they are unprepared" (p.57).

With respect to EVT and EST's, the same APA standard states, "In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm" (p.4)... "In those areas in which recognized professional standards do not yet exist, psychologists exercise careful judgment and take appropriate precautions to protect the welfare of those with whom they work. They maintain knowledge of relevant scientific and professional information related to the services they render, and they recognize the need for ongoing education" (American Psychological Association, 1992, p.3).

An addendum to the psychiatric annotations states, "A psychiatrist's treatment plan shall be based upon clinical, scientific, or generally accepted standards of treatment" (American Psychiatric Association, 1998, p.24). Counselors are advised to "recognize the need for continuing education to maintain a reasonable level of awareness of current scientific and professional information in their fields of activity" (American Counseling Association, 1997, p.4). These guidelines highlight the need for professional associations to address issues of competency in techniques and practice. When emerging standards of care do not exist, social workers are advised to exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm (National Association of Social Workers, 1998).

Professional associations do not dismiss their affiliates from accountability with regard to the advancement of knowledge and professional abilities and the use of the most advanced procedures in their work endeavors; however, the latter requires a valid and reliable knowledge base upon which to build. It is a positive situation that psychotherapists are obligated to validate existing treatments and establish new ones. Managed behavioral health care may be responsible for this. The basis of a profession's longevity and growth are based upon this.

It is advantageous that psychotherapists, government agencies, and managed-care representatives spend time and money on research geared toward validating the efficacy of the psychotherapeutic process and specifying the most time-efficient and effective approaches. The personal arguments and opinions by managed behavioral health care personnel and mental health professionals, regarding optimal treatment modalities and techniques, are moot without the data and research to back them up. Chodoff (1996) admonishes that "serious attention should be paid to the need for a standard of care defining competence in psychotherapy and that professional organizations should enunciate and enforce requirements that psychotherapists whose treatment practices fall below such standards should be considered unethical. Failing this monitoring device...the doctor is obligated to do what is in the patient's best interest..." (p.303).

Competence, as it relates to ethical issues, is a concern directed toward managed care companies who at times hire less well-trained, less costly personnel (Sullivan, 2000). Robert Storch (1995) agrees adding, "These individuals are nonprofessionals who have very little, if any, clinical training. They tend to evaluate cases along criteria which have to do with cost containment, actuarial expectancies of outcome and the proscribed

allocation of service to specific diagnostic conditions. They are considering how much psychotherapy is generally necessary to medically resolve the current condition, and prevent the condition becoming worse and, from their point of view, more costly" (p.37). Proponents of managed behavioral health care argue that their practices protect the public by weeding out "charlatans" who bleed client's for money (Austad, et.al, 1998).

Mental health associations urge their constituents to work toward social change and scientific (American Counseling Association, 1997; American Psychiatric Association, 1998; National Association of Social Workers, 1996) The APA guidelines state that psychologists have a social responsibility to "comply with the law and encourage the development of law and social policy that serve the interests of their patients and clients and the public" (American Psychological Association, 1992, p.4) .

Practitioners believe this mandate should be extended to professionals or employees working for managed care companies. Giles and Marafiote (1998) and Sank (1997) advocate for holding managed care accountable for treatment denials and untoward treatment outcomes and urge therapists to report these issues as ethical infractions. Code 8.05 of the APA (1992) states, "If an apparent ethical violation is not appropriate for informal resolution, psychologists take further action appropriate to the situation, unless such action conflicts with confidentiality rights in ways that cannot be resolved. Such action might include referral to state and national committees on professional ethics or to state licensing boards" (p.15).

Pipal (1996) believes that therapists have largely refrained from reporting these issues because of fear of reproach and dismissal from managed care panels, adding that "professionals, despite the best ethics information, remain overwhelmed and paralyzed by

the ethical dilemma presented by managed care” (p.127). Austad, et.al. (1998) believe that professional codes of ethics “need to be revised to make it more relevant for clinicians who must cope with a changing health care environment (p.71). We need to develop a well-articulated social ethic to guide psychologists, and all mental health professionals, to decide how those who need psychotherapy gain access to it” (p.73).

Bilynsky and Vernaglia (1998) highlighted concerns about client abandonment. Specifically, when sessions are limited by an HMO and the client is determined by the therapist to need more treatment, the latter is ethically and legally responsible to provide the care; issues now center around financial reimbursement. Regarding the therapists, the authors state, “When difficulties arise, because of a lack of treatment options or when authorization for hospitalization is denied, the clinician is held responsible” (p.57) “the law ultimately holds the psychologist responsible for clinical decisions” (p.58).

Bilynsky and Vernaglia (1998) also advise gaining knowledge of the insurance appeal process for clinical decisions, cognizant of their commitment to client care and a willingness to intervene with the organization on the client’s behalf. Yet, providers must not be penalized for these appeals. “Not appealing incorrect HMO decisions, however, can have legal ramifications for the psychologist. The courts have decided that clinicians, not the insurance carriers, are ultimately responsible for client care” (p.64).

Recommendations

• Though the future of managed behavioral health care is unknown, it appears that its presence in the mental health fields is relatively permanent: It is likely that the policies of managed behavioral health care will change as therapists group together to regain

autonomy and function interdependently with the former. Vying for limited funds lies at the heart of the managed care debate. Many professionals support development of EVT or EST which, by nature, will give the mental health fields more of the hard core, scientific data base from which arguments treatment planning can be successfully fought.

Anders (1996) argues for reliable data of treatment outcomes; standardized treatments for specific ailments. As managed behavioral health care is increasingly traded publicly and acquired by for-profit companies, research decreases. Research on outcomes and treatment guidelines has to come from agencies outside managed care who can be more objectively motivated. The treatment of mental health disorders has long been considered art as well as science. Future research will determine if the important therapist and client variables are amenable to scientific investigation and measurement.

Seligman's (1995) suggestion that client-based survey data be included in such research, to bolster its external validity or clinical utility is one relevant change, as would clinical outcome measures of the psychotherapist's treating these clients. Though the validity and reliability of surveys of client satisfaction is questionable (Miller, 1996), such survey data would be a useful supplement to diagnoses and symptom measures when based on standardized measures of satisfaction and change.

The status of current research outcome measures is more in line with the scientist-researcher model and results based on them carry more validity with managed behavioral health care companies and the government officials responsible for providing grant monies. Even Chambless and Hollon (1998), strong proponents of efficacy research results, acknowledge that well conducted and examined, multiple single case studies offer an alternative method for addressing the artificial, anti-ecological issues of laboratory

research. These research designs allow for a greater understanding of intricate change variables and of the individual characteristics which promote health.

Psychotherapeutic clinicians and researchers must also work collaboratively to integrate strategies of different psychotherapy models into the most clinically useful approaches. Practicing psychotherapists are ethically obligated to provide clients with the most efficient and proven effective treatments available (Granello & Witmer, 1997). Unfortunately, research articles remain the bane of the psychotherapist who finds them difficult to read and irrelevant to practice (Weisz et. al., 1995).

It is possible that efficacy research has been embraced because it excludes those 'confounding' variables that experienced therapists know are important determinants of client change (Goldfried and Wolfe 1998). The relationship between theory and practice should be mutually informative. Goldfried and Wolfe (1998) believe the experience and wisdom of the psychotherapist cannot be overlooked. Because clinical observations are often not clearly articulated, may be unsystematic or idiosyncratic, and often informal, it is less likely that these insights can add to a reliable body of knowledge. Researchers, however, need to study clinically significant and ecologically valid subject material.

EVT and EST research, theoretically based, to date has been instructing practice. Research may need to take direction from practice; information by experienced clinicians could be used to develop research methodology which is more ecologically useful and includes the person and process variables that psychotherapy research has found to correlate with client progress. Clinical innovation and discovery lies with the practitioner; so too does innovations that expand on existing techniques (Wilson, 1995).

Weisz et. al.'s (1995) examination of the few clinic-based child psychotherapy studies available at the time concluded that, when a treatment was compared to a control or placebo, clinic-based effect sizes were consistently smaller than those obtained under the carefully controlled laboratory setting and led to the conclusion that researched-based interventions produce more positive results. The authors offered a number of suggestions for enriching the data base of clinic-based research findings.

First, and also supported by Keisler (2000), individual and clinic psychotherapists need to collect data on their clients, using of multiple baseline case study and quasi-experimental approaches, and identify predictor variables for future study. Research could then approximate the real life multi-problem situations of heterogeneous groups of clients who are referred not recruited, in clinical settings, provided by actual clinicians with large caseloads, without extensive pre-therapy preparation for treatment, with eclectic orientations of non-behavioral methods, and flexible non-manualized treatments.

Weisz et. al. (1995) believe the specific mechanisms of change in research based outcome studies have not been delineated. The specific processes responsible for a treatment's effect size over control and placebo need specification so they can be integrated into actual practice; in turn, problems or results examined in actual clinical settings can be further examined back in the research laboratory. It is important to know if some of the results laboratory RCT are due to conditions inherent to that setting that cannot be generalized to clinical settings. How and why one therapy surpasses another is important information, particularly in light of the fact that common processes across therapies appear to account for a percentage of the variance in therapeutic change. As

efficacy researcher point out to adherents of non-efficacious treatments, if a treatment cannot be proven effective for real clients, it must be abandoned for those that are useful.

As a minimal alternative, efficacy research must be extended and externally validated within applied settings (Borkovec and Castonguay, 1998). Concerns about randomization and internal control can be addressed while still addressing causal agency within the laboratory; in the long run, efficacy research results may prove to be internally and ecologically valid. Efficacy studies must further delineate the specific variables of change so these effects can be tested in actual practice and, in turn, be refined in the laboratory setting. The ideal research maximizes internal and external validity; studies in which efficacy and effectiveness features converge (Chambless and Hollon, 1998).

Quasi-experimental research approaches, such as naturalistic and case-studies, are needed to achieve the goal of understanding how therapy works in clinical practice (Persons and Silberschatz, 1998). Models to address these variables exist. The effectiveness study, advocated by Seligman (1995), is a useful, naturalistic approach that assesses how psychotherapy actually works in the field. As Persons and Silberschatz (1998) note, it would be a fallacy to equate empirical validation with the method of randomized clinical trials or EVT and EST research techniques.

Because efficacy research is more technically sound, RCT can be adapted to include clinically relevant criteria from effectiveness research (Persons and Silberschatz, 1998). These studies would be more appealing to practicing psychotherapists dealing with complex cases. For example, a comparison could be made between one psychotherapy that rigidly adheres to EVT and EST manuals while another allows therapists room to flexibly tailor the same approach to the individual case.

The Pennsylvania Psychological Association has established a Practice Research Network where over 200 psychologists are partaking in an ongoing study. All new psychotherapy clients will be administered an assessment test battery which includes measures of therapist characteristics and process variables through the use of session audio-tapes. The correlational results will be used to guide additional research into causative processes. The results can then be taken back to the laboratory where controlled research can further explicate the unique, active processes of change and common elements of all psychotherapies that factor into successful outcome.

Research that matches interventions with relevant client characteristics would inform about which techniques are personally compatible for clients at different stages of change; research on the psychotherapeutic relationship variables that enhance the psychotherapy alliance is also necessary as the relationship is clearly another powerful influence of client progress. It may, for example, turn out that client resistance is an important mediating variable between a treatment modality and positive outcome.

Knowing which psychotherapies are most effective with such individuals is necessary to establish efficacy. It is this type of information that is currently lacking in psychotherapy manuals but desperately needs clarification. According to Goldfried (1998), the current emphasis on diagnosis and type of psychotherapy must be supplemented with balanced with an emphasis on client and psychotherapist variability.

Goldfried (1998) suggests that providing training, in empirically supported psychotherapies, to individuals who lack certain personal qualities of empathy and warmth as well as skills in relating to and understanding others will not necessarily lead to positive outcomes. Instead of reducing therapist variability in psychotherapy research

through training manuals, psychotherapists need instead to study those professionals who consistently secure the best results and attempt to discover the psychotherapist variables and therapy interactions that appear to be linked to superior outcome.

Treatment research needs to be designed that compares the more behavioral and cognitive-behavioral modalities with more traditional approaches to psychotherapy. In addition, there needs to be quality outcome studies that compare shorter-term treatments with traditional, unlimited psychotherapy (Miller, 1996). To say that behavioral and cognitive-behavioral approaches are efficacious, using current methodologies, does not allow for comparison with longer-term, more globally directed treatments that are potentially more effective but which have not been properly evaluated because of the time-consuming nature of conducting such research.

Weisz et. al. (1995) point out that the majority of efficacy studies have better outcomes because they employ behavioral interventions and cognitive-behavioral methods with little attention given to psychodynamic, family or eclectic approaches, although a majority of psychotherapists continue to employ the latter approaches. It would be important to know if a longer-term treatment produces both more specific and global results that are more enduring. The time limitations of present studies do not allow for such comparisons nor do they allow ascertaining delayed treatment effects. Chambless and Hollon (1998) suggest that evaluators consider the entire body of controlled research literature on a treatment when they consider its efficacy.

Because behavioral and cognitive psychotherapies are more conducive to the best current methodological designs, results demonstrating their efficacy are in abundance. However, it is recognized today that psychotherapies such as humanistic, psychodynamic,

client-centered, existential, etc. can be evaluated under controlled research settings; by breaking down the approach into its unique and specific parts, comparisons can be made between groups that omit one component only from the technique thereby demonstrating whether or not that technique is responsible for significant changes in client outcome.

Staunch advocates of EVT, EST, and RCT (Persons, 1998) stress that because a treatment has not been demonstrated to be effective does not mean it is not. Borkovec and Castonguay (1998) suggest a dismantling approach to outcome research. Existing EVT and EST can begin the process of deciphering the most important active ingredients through these means. The dismantling approach allows researchers to discover whether common factors or an specific ingredients of an approach is responsible for change.

Because common factors contribute to psychotherapeutic effectiveness, further study of them is warranted. It is also necessary to address process variables since these are relevant to psychotherapeutic progress. Process variables are amenable to study through parametric designs that allow the altering of levels of dimensions of process variables. Parametric designs also allow more solid conclusions about active therapy ingredients; if varying the levels of active ingredients cause varying levels of change, whether linearly or geometrically, the causative relevance of these factors will be further explicated. This information is crucial when insurance and government policy is made.

Chambless and Hollon (1998) are speculative of using meta-analysis to accomplish the task of comparing all research studies on the market today. Although meta-analysis compensates for the problem of limited power in studies on psychotherapy effectiveness, these authors believe that it obscures qualitative differences in how treatments are executed. It is recommended that meta-analyses be used with caution,

unless detailed information is available about the design and data of the study. In contrast, Granella and Witmer (1997) recommend both the use of meta-analysis and the compilation of all psychotherapy outcome research across disciplines.

Meta-analysis could allow the more traditional psychotherapies to be compared with comparable studies, at least at the exploratory level where further research could then be designed which validates the most important change factors. Communications between psychotherapists of different disciplines and schools of thought would facilitate the development of a larger objective database. It would also facilitate discussion about successful techniques that have not yet been researched in efficacy studies; effectiveness according to counselor observations, outcome measures, and professional opinions about which techniques work best with specific diagnoses.

The current fiscal pressures toward psychotherapy efficiency are laudable and healthy for the growth of the field of psychotherapy as a whole. Change and growth are to be embraced not resisted because of allegiance or fear. The goal of raising the scientific respectability of all divisions of psychotherapy cannot be disputed. However, the scientist vs. practitioner or science vs. art dichotomy may prove to be a more than a historical philosophical debate. A percentage, albeit unknown, of psychotherapy will remain an art form because human beings are too complex to break down into completely understandable parts and the creativity and thinking capabilities of people necessitate spontaneity and adjustment to unexpected changes in the psychotherapeutic relationship.

However much efficacy research teaches, in the end, allowance must be made for individual differences between all parties in the therapy relationship. This issue needs more attention when one considers that policy and the financial future of the field are at

stake. Practicing psychotherapists will eventually need to consider the EVT, EST and RCT literature, at least initially because of pressure from third-party payers, professional institutions, the government, funding sources, and consumers who demand efficiency for their money as well as effective interventions (Hayes, 1995; Wilson, 1995). It is perhaps not advantageous to model psychotherapy research after that conducted in the natural sciences. Although psychiatry and pharmacotherapy research is more scientifically rigorous and empirically scrutinized, it may be necessary and desirable not to seek complete equivalency with these fields. Attention needs to be given to validating the differences between psychotherapy and these other areas that impact it.

A number of authors advocate for strong managed behavioral health care reform (Rabasca, 1999). Grassroots movements, involving professionals and laypersons alike, are applauded as a means to put pressure on Congress for further reform measures. The numerous proposed and passed bills relevant to changes for the mental health field, it's professionals and consumers alike, have been detailed earlier in this analysis.

Because of the business aspects of working within the managed behavioral health care plans, psychotherapists who better understand business and finance principles would be in a better position to market their services directly to employers or managed behavioral health care organizations and make what the field has to offer more visible and available (Rabasca, 1999, February). Kiesler (2000) urges psychotherapists to gain a better understanding of capitation as well as the changes in the frequency of mental health problems now being treated. It is recommended that psychotherapists consider training to expand areas of expertise and contribution in such things as preventive community services, improving social institutions, and social policy (Humphreys, 1996).

CHAPTER III

Procedure

Introduction

This chapter is divided into two corresponding sections. In the former section, theoretical issues pertaining to procedural decisions in qualitative inquiry are delineated. In the latter section, the specific application of this theory to the procedures of this study are outlined. The decision to separate this chapter into mirror sections stemmed from a desire to make the reading of text clearer and to inform novice readers of qualitative theory, thereby enhancing their understanding of its use in this analysis.

Assumptions and Rationale for a Qualitative Design

The design of a study connects the research questions, data collection methods, data analysis, and the conclusions. Qualitative analysis was employed in this study. In it, "The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting" (Creswell, 1998, p.15). In contrast to the quantitative researcher's focus on the amount of something, the qualitative researcher focuses on its form or character. Qualitative researchers search for meanings and descriptions of experience rather than explanations and measurement. Moustakas (1994) adds, "Only what we know from internal perception can be counted on as a basis for scientific knowledge" (p. 45). There is a focus on perspectives because of the interdependence of knowledge on the perceptions and life experiences of the individual.

The characteristics of good qualitative research have been outlined by different authors. For Creswell (1998), it is conducted in a natural setting with the researcher as a key instrument in data collection and summarized with aids that employ words and pictures. Knowledge is contextual and necessitates checking with those who provide it to be sure their intentions are accurately interpreted (Lincoln and Guba, 1985). It is inductive; the design evolves as participants illuminate relevant dimensions of issues. Though each person's perceptual reality is unique, common knowledge exists and can be developed when explored by methods allowing in-depth understanding.

For Lincoln and Guba (1985), the goal of qualitative research is to discover constructs from the data themselves; hypotheses are developed through constant comparison of the data and formulations in a cyclical design (Lincoln and Guba, 1985). According to Kvale (1996), the goal of the qualitative researcher and inquiry is "a tale that does justice to the subjects' stories of their lived world and that conveys new and valid knowledge and insights" (p. 80). The researcher carefully views their impact on the research process and how their personal biographies shape a study.

Phenomenological Philosophical Perspective and Approach

The qualitative tradition employed throughout this study was the Transcendental Phenomenological Approach. A phenomenological study "describes the meaning of the lived experiences for several individuals about a concept or phenomenon" (Creswell, 1998, p.51). For Moustakas (1994), the phenomenological model is "a way of utilizing description, reflection, and imagination in arriving at an understanding of what is, in seeing the conditions through which what is comes to be" (p. 175).

Phenomenology is rooted in the philosophical perspectives Heidegger and Sartre, and was founded by German mathematician Edmund Husserl at the turn of the century (Marshall and Rossman, 1999). For these philosophers, human consciousness and experience are proper subject matter for investigations. Phenomenology is knowledge as it appears to consciousness; holistic perceptions of one's immediate awareness and experience; understanding depends on the interrelationship between conscious description and the underlying dynamics of experience which enable understanding the essence of the experience (Moustakas, 1994).

Husserl's concept of horizons describes the process of viewing experiences from the infinite number of perspectives from which objects, experiences, ideas can be examined. Each perception adds to the richness of an experience. According to Kvale, phenomenology "describes in detail the content and structure of the subjects' consciousness...to explicate their essential meanings...to articulate the pre-reflective level of lived meanings, to make the invisible visible" (p. 53). This ontological view defines reality as what people perceive it to be (Creswell, 1998). The only certainty is what one thinks, feels and perceives; objective reality existed only through representation in the subjective mind. Meaning is in the act of experiencing (Moustakas, 1994).

Two concepts form the core of transcendental phenomenological data analysis: noema, and noesis (Moustakas, 1994). Noema constitute the what that is experienced while noesis comprise the way in which the what is experienced. Noema are the perceptions one sees each time something is viewed or judged; the meaning given to what is presented in consciousness during the act of perceiving, remembering, imagined, or judging. Noema enable us to understand what something is and means. Noesis describes

how one experiences what is experienced. Experiences are reflected upon so their meanings can be discovered; the material of consciousness or perception assume shape and meaning when they are reflected upon (Moustakas, 1994).

Phenomenological concepts precipitated the era of post-modern constructions of reality. Prior positivists views, associated with the scientific method and quantitative approaches to science, created a dichotomy between the objective world and subjective images; knowledge mirrors objective reality and science uses the scientific method to arrive at conclusions and predictions (Kvale, 1996). Post-modernism and phenomenology view knowledge as inter-relational and communal; it is neither inside the person or outside in the world but exists in the relationship between the two. (Kvale, 1996). Useful knowledge is achieved through discourse aimed at consensus. It is intimately connected to context, laced with personal biases, and not easily transferable (Creswell, 1998).

The goal of phenomenological inquiry is to understand an individual's perceptual experience (noema) and the historical dynamics or essential structure (noesis) of that experience. The psychological approach to phenomenology stresses individual, not group, experiences. The researcher's challenge is to adequately uncover and describes these phenomenon. The researcher takes participant's perceptions and derives new but accurately reflective conceptions of the experiences in psychological terms.

Conceptualization, analysis, and formulations are derived from the data; new data result in changes in formulations, and so on until no substantial changes in essential meanings can be made and there is a sense of closure about what was understood and learned. The researcher takes an active role in phenomenological research, using him or herself to gather knowledge inter-rationally (Kvale, 1996). It is important, therefore,

that the researcher bracket preconceptions in a process called the Epoche. Personal beliefs, memories, perceptions, and judgments can lead to selective understanding of participant's experiences. Bracketing allows a greater opportunity to understand the meanings of participants. Full understanding of one's own presuppositions becomes essential (Marshall and Rossman, 1999; Moustakas, 1994).

Induction guides phenomenological data analysis. Statements by participants are categorized into clusters of meanings or themes. These themes are tied together into overarching themes to consolidate the experiences of participants. In the end, essential structures of the experiences are developed that describe what is experienced and how it can be understood. Essential meanings or the essential invariant structure are what remain constant after all possible forms are viewed (Kvale, 1996); a brief description that typifies the experiences for all (Moustakas, 1994).

Qualitative Inquiry: Sampling Procedures

Qualitative sampling procedures are purposeful (Lincoln and Guba, 1985). Purposeful sampling is characterized by serial selection of sample units; each unit is selected only after the previous unit was analyzed to extend what is currently known). A number of sampling strategies exist. In maximum variation, samples are selected to provide the broadest range of information possible (Lincoln and Guba, 1985). Criterion sampling ensures quality assurance because all cases meet some specified criterion (Miles & Huberman, 1994, in Creswell, 1998). Sample size is based upon a need for additional information. Participants are interviewed until themes are saturated and data from another

interview does not add appreciably to themes developed or does not lead the researcher to change the essential structure induced from the data.

Setting

Qualitative research is a context-laden methodology. Qualitative research recognizes that human actions are influenced by the context in which they occur, making naturalistic studies of real-life behavior desirable. Norms, traditions, roles, and values are influential aspects of the environment. Marshall and Rossman (1999) state, "...the study should be conducted in the setting where all this complexity operates" (p. 57). It is desirable to explore realities directly in the context in which they developed and normally occur. Removing participants from their natural settings can lead to contrived findings (Creswell, 1994).

Entry, Access, Rapport, and Ethics Issues

In a qualitative analysis, it is the responsibility of the researcher or interviewer to establish an atmosphere in which each participant feels safe and uninhibited to freely talk about their experiences, thoughts, beliefs, and feelings about an issue or topic (Kvale, 1996). Marshall and Rossman (1999) state, "...building trusting relations must proceed in conjunction with gathering good data" (p. 80). Interpersonal skills are important for building rapport and gathering useful knowledge. Lincoln and Guba (1985) note that trust is a developmental process where the researcher demonstrates to participants that responses will be safeguarded, requests honored, and hidden agendas avoided.

The interviewer achieves an empathic, open atmosphere through words, tone of voice, expressions, and gestures. A number of interview techniques facilitate subject's in-depth exploration of meanings; in the process, these techniques serve as a verification step, assuring clarification and delineation of subject's intended meanings and lived experiences. Follow-up questions probe for meaning clarification and make statements less ambiguous and more trustworthy. In the ideal interview, analysis and interpretation proceed during the interview (Kvale, 1996).

The following personal researcher attributes also facilitate obtaining credible knowledge: patience, respect, thoughtfulness, sincerity, researcher authenticity or genuineness, interest in what is said, and being present with the interviewee or participant. Kvale (1996) stresses empathic listening to enable subjects to open-up and allow the researcher to explore their experiences without presuppositions. Empathic listening is essential for obtaining valid data or knowledge. Without truthful participant responses, the credibility of the study cannot be determined. The open-ended nature of the qualitative research interview necessitates the use of open-ended questions; i.e., questions of what or how, not why. This also facilitates participant's open exploration without imposing the researchers desired direction onto the question.

The interviewer is gentle when posing questions and creates a non-threatening, informal environment. The conscientious interviewer is sensitive to what is said verbally and nonverbally, to how it is said, steers participant's toward pertinent information, remembers key meanings to be followed-up at a later time, and is critical not to take all that is said at face value (Kvale, 1996). The goal of these techniques is to clarify and

extend interviewee's meaning statements, thereby initiating theme interpretation and analysis throughout the interview.

A pre-interview briefing and a post-interview debriefing facilitate access and entry; both are related to researcher disclosure. They address issues of reciprocity by providing informal feedback to participants. The level of disclosure ensures non-deception but does not reveal material that could bias participant's responses. Disclosure may involve discussing the situation, purposes, goals, and significance of the study, use of recording devices, and confidentiality (Marshall and Rossman, 1999).

Entry, access, and rapport are related to the ethical issues of confidentiality, informed consent, privacy, and protection from harm. The researcher emphasizes the voluntary nature of participation and freedom to withdraw from the study, clarifies any misconceptions, and addresses any negative effects for participants (Moustakas, 1994). Interviews involve a careful balance between persistently pursuing scientific knowledge and respecting the integrity of the interviewee. The interviewer gauges the interviewee's emotional well-being and accommodates questions to each person (Kvale, 1996).

Role of the Researcher

Moustakas (1994) states that in human science research the self of the researcher is present throughout the process. In a qualitative research interview, the interviewer is the key instrument for obtaining valid, credible information. Kvale (1996) states that the "outcome of an interview depends upon the knowledge, sensitivity, and empathy of the interviewer" (p. 105). Marshall & Rossman (1999) and Lincoln and Guba (1985) suggest

that a researcher's relevant academic and professional experiences need to be delineated, as these qualifications enhance the reliability and validity of the procedures and findings. Growing from this knowledge, the researcher facilitates exploration of pertinent issues.

Qualitative inquiry is a value-laden and biased process. The personal values of the researcher and participants cannot be separated from the knowledge uncovered nor is it desirable to do so since knowledge is linked to context (Lincoln and Guba, 1985).

Interview data form the meanings, themes, and conclusions developed and recommendations made. Data is mediated through the interviewer's voice. The interviewer is part of the methodology and effects the evaluative process (Kvale, 1996). Phenomenology attempts to lessen the distance between the researcher and participants in the study. A credible, validity study depends on the integrity of respondents' answers.

Kvale (1996) and Marshall and Rossman (1999) caution against two counter-productive stances a qualitative researcher can take. The first is over-identification with the subject or material of the investigation. This is akin to countertransference in the therapeutic relationship and has been referred to as 'going native;' an enmeshment with the interviewee in which the researcher is unable to take an objective stance toward the data. In the second, affiliations to organizations, beliefs, or persons lead an investigator to ignore some facts or highlight others, to the detriment of an unbiased investigation of a phenomenon. The researcher avoids projecting cultural values onto interviewees.

Data Collection Methods: Interviewing and Level of Data Collection

Data collection in phenomenological inquiry proceeds through interviews, focus groups, behavioral observations and any means of collecting data through verbal or visual

channels (Creswell, 1998). Phenomenological interviews are conversations with a purpose (Marshall and Rossman, 1999). They are interactive and involve informal, open-ended questions, create a relaxed and trusting atmosphere, and evolve within a climate where participants feel comfortable to be honest about their experiences.

Interviews are especially suited for exploratory research to describe people's experiences, to understand the meanings of their lived worlds, and to elaborate personal perspectives. They involve a high degree of face-to-face interaction, allowing deeper understanding of the perspectives involved in issues (Marshall & Rossman, 1999). Interviews allow one to gather large amounts of data quickly and to follow-up and clarify data immediately. The research interview is an alternative conception of social science research, more akin to the philosophical underpinnings of the humanities and the process of conducting psychotherapy. Marshall and Rossman (1999) believe that, by coding issues and experiences into operational variables and imposing the researcher's view onto subjects, valuable data is lost.

According to Marshall and Rossman (1999), qualitative research reserves some flexibility with regard to research questions and design so as to adapt to individual needs, cognitive styles, and world views. Interviews vary in terms of structure and the latitude interviewees have to respond to questions; questions are general enough to permit exploration but focused enough to delimit the study. Semi-structured interviews have "a sequence of themes to be covered, as well as suggested questions. Yet at the same time there is an openness to changes of sequence and forms of questions in order to follow up the answers given" (Kvale, 1996, p. 124). Kvale (1996) however, contends that if one knows what to ask for, one can conduct short interviews rich in meaning.

Data Analysis Procedures

Data analysis brings order, structure and interpretation to data (Marshall and Rossman, 1999). Qualitative data analysis involves theoretical and contextual decisions about analyzing data (Kvale, 1996). Though the goal is to describe the what and how of experiences, the specific analytical design chosen depends upon the purpose of the study, the subject matter of the interview, and the thematic questions posed at the start of the investigation. Preliminary research questions and related literature provide guidelines and suggest categories to code the data during analysis (Marshall and Rossman, 1999).

Interviewing and data analysis are inseparable processes in a qualitative study; questions during the interview facilitate the delineation of themes. When the interviewer interprets subject's statements through follow-up questions, in-depth understanding develops. This dialectical, cyclical process is called the Constant Comparative Method; data is simultaneously collected, transcribed, analyzed, and interpreted to assure that the essences and themes have been derived from them (Creswell, 1998; Kvale, 1996). The process continues until modifications of themes and categories are no longer necessary and the relationship among critical categories are established, defined, and integrated into a credible interpretation (Marshall and Rossman, 1999). Creswell (1998) likens qualitative analysis and the resulting narrative to the metaphor of a camera lens: panning out, zooming in, then panning out again.

Phenomenological inquiry requires being faithful to the data and expressing experiences from participant's viewpoints. Therefore, the researcher initially engages the text naively, searching for statements that illustrate categories of meaning. Moustakas

(1994) states, "Use quotations. Capture participants' views of their experiences in their own words" (p.2). Data is first organized by reading text in its entirety to get a sense of the whole before breaking it apart (Moustakas, 1994). Relevant statements are listed; observation and field notes are recorded. Salient themes and categories, recurring ideas, patterns of beliefs and behaviors are then identified. Categories become the "buckets or baskets into which segments of text are placed" (Marshall and Rossman, 1999, p. 154); Categories are internally consistent but divergent from one another.

Data is coded by marking meaningful statements into a coding scheme. This can be accomplished with a computer program or color-coded by hand. Through coding, new ideas or themes may emerge, necessitating changes in categories themes that are then recoded. Meaning interpretation involves going beyond what is said to discover structures and relations of meaning that are not immediately apparent in the text. Next, the plausibility of the emerging understandings are tested through direct comparison with data. Understandings are challenged in a veridical reading of the text: examining statements for consistencies and contradictions (Kvale, 1996). Data are analyzed for how well they illuminate the questions being explored and contribute to emerging ideas. In the critical readings, deeper meaning is sought.(Marshall and Rossman, 1999).

These patterns are challenged for other plausible explanations until the researcher demonstrates that the interpretations made are the most plausible ones for the data. Finally, the report is written which develops the essence of an experience; essential, non-redundant themes that are detailed and tied together in descriptive statements. Qualitative narrative can take the form of a realist tale (VanMaanen, in Marshall and Rossman,

1999); realistic reporting of the data and interviews sets the standard for credibility, quality, and respectability in qualitative work.

Because of the exploratory nature of this study, Moustakas' Transcendental Phenomenological Approach provided the conceptual framework for data analysis. In this approach, the researcher brackets preconceptions in the Epoche, derives significant statements from the recorded data in a process called Horizontalizing, develops meanings from these statements by clustering them together into themes, provides textural and structural descriptions of the themes in a process called imaginative variation, and derives an exhaustive description of the phenomenon or its essential invariant structure.

Transcendental Phenomenology is outlined below. The method is a modification of the Stevick-Colaizzi-Keen method and involves the following steps. A full description of the researcher's experience of the phenomenon is provided. From the transcripts, the researcher analyzes each statement for its significance in informing the description of the experience. All relevant, nonrepetitive, statements are listed to derive the invariant horizons or meaning units. These invariant meaning units are clustered into themes which are synthesized into a description of the textures of the experience which include verbatim examples. Through imaginative variation, a structural description is developed. A combined textural and structural description of the data are developed.

Each of the above steps are conducted for the transcripts of each participant. Finally, a composite textural-structural description for all of the participants is constructed of the meanings and essences of the experience; this composite description integrates all of the individual textural-structural descriptions into a universal description

of the experience for the group of research participants as a whole. In what follows, a more detailed description of each of these analytic steps is provided.

Epoche or Bracketing

Qualitative analysis is value-laden because of the subjective personal experiences of researchers and participants. Procedurally, it is important that the researcher's preconceived ideas about the phenomenon are put aside and the main focus become the personal experiences of the subjects alone. Epoche means bracketing one's preconceived notions about topics and issues or refraining from judgment so that phenomena can be freshly or naively examined. The presuppositionless state advocated by Husserl is achieved by examining one's own beliefs, values, and ideas from data collection and analysis and being open to other's perceptions of an experience.

Epoche requires disciplined and systematic efforts. The first step is openly encountering oneself; knowing one's own phenomenological experiences and becoming transparent to oneself. No position on issues is taken and all viewpoints are given equal weight. The credibility of the interview process is dependent upon the researcher's ability to be honest and unbiased (Marshall and Rossman, 1999). By setting aside prejudices, beliefs, and preconceived, the researcher can hear and understand what lies within spoken and written text. Participant's meanings become clearer the longer the researcher or interviewer empathetically listens to issues.

Significant Statements: Horizontalizing

Phenomenological reduction begins the process of identifying the essence of a phenomenon (Marshall and Rossman, 1999). In Moustakas' (1994) phenomenological approach, the original protocols or texts are divided into statements or appropriate text units, in a process called Horizontalization; the smallest piece of information about something that can be interpreted in the absence of any additional information. These units are the basis for developing themes and categories; statements are put together that go together (Lincoln and Guba, 1985). Data are examined sentence by sentence with each thought considered singularly and in its totality.

Each statement adds meaning and clarifies the participant's feelings, thoughts, values, and beliefs. Moustakas (1994) suggests delineating each time a transition in meaning is perceived and extracting interview statements that describe how individuals experience the topic. Horizontalization involves being open to every statement and granting each comment equal value. The researcher must employ all constructive conversation skills to facilitate comprehensive disclosure from participants.

Invariant Horizons: Meanings of Statements

A list of significant, nonrepetitive, non-overlapping statements is developed and transformed into clusters of meanings units. (Creswell, 1998). The statements are the invariant horizons or text units later used by the researcher for analysis. Horizontalization is a pre-reflective description of things just as they appear. Creswell (1998) refers to these as codes or categories, described with psychological or phenomenological concepts which are compared with one another. The meaning units are clarified by relating them to one

another and to the whole interview (Moustakas, 1994). The researcher writes down ideas to uncover properties of knowledge from which rules can be written and further instances can be identified (Lincoln and Guba, 1985). Statements are examined for content; meaning units are catalogued into a tentative category or theme. Successive units are similarly treated similarly; similar statements are included in the same category.

Themes of Meanings

Themes describe the textures of the experience (Marshall and Rossman, 1999). They are a clustering of horizons into constructs that portray the experience. Initial categories are formed by reflecting on the larger thoughts represented in the data, looking for multiple examples for each. Moustakas (1994) adds, "Reflection becomes more exact through corrections that more completely and accurately present what appears before us. Things become clearer as they are considered again and again" (p. 93). Each statement takes on a distinctive character through the conscious experience of the researcher. The Epoche is important to allow one to see statements as the participants meant them to be understood (Moustakas, 1994). Counts of the categories or codes take place to determine their frequency of occurrence.

A theme is a name or phrase that succinctly captures the essence of the statements and meanings. A theme begins as a propositional statement or rule that is the basis for decisions about inclusion and exclusion in the category. Themes must be indicated by all of the data in that category. Themes are examined for relationships among them; sub-categories or sparse categories are further explored in subsequent interviews. Lincoln and Guba (1985) offer rules to guide the decision to stop data collection: sources have been

exhausted, categories are saturated (they are sufficiently developed so that new information only adds small amounts of insight relative to the effort required to attain it), and new information is very far removed from the themes that have been developed and does not appreciably add to the knowledge.

Textural Descriptions

The meaning units derived from all significant statements, together with the themes or categories, are listed and the researcher writes a textural description of the experience; a narrative of the experiences with verbatim examples. For Creswell (1998), quotations provide "specific concrete evidence, in the informants' words, to support a theme" (p.171). Textural descriptions join together the horizons and themes. They are derived from the researcher's reflections on the participant's experiences and effectively capture the situation and relationships for each participant (Moustakas, 1994). Textural descriptions include the thoughts, feelings, examples, and ideas of participants that comprise the meaning of a phenomenon (Moustakas, 1994).

Structural Descriptions: Imaginative Variation

Structural description or imaginative variation is then employed. The researcher constructs a description of how the phenomenon was experienced (Creswell, 1998). For Moustakas (1994), imaginative variation seeks all possible meanings by varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives. The structural description is an account of "the underlying

dynamics of the experience" (Moustakas, 1994, p. 135); the themes, qualities, and conditions that account for it.

Intuition and imagination are necessary to arrive at universal structures that provide a dynamic picture and account of participants' experiences. The researcher reflects on and analyzes the data beyond the appearance or what is given, searching for deeper meanings. Descartes believed intuition was an inborn talent that aided production of solid judgments and knowledge about human experience (Moustakas, 1994). The goal is understand the essence of an experience and synthesize them into a coherent picture of the conditions that underlie and precipitate them (Moustakas, 1994). At this stage, knowledge moves from the level of facts to ideas.

Composite Textural Description: Exhaustive Description of Phenomenon

The final stage of phenomenological analysis is structural synthesis of meanings and essences. Meanings are tied together into overarching themes or general descriptions of what was experienced and how (Creswell, 1998). They provide the reader with a unified understanding of the meaning of an experience for the individuals involved. Invariant themes for the group of participant data are developed into composite textural descriptions. Imaginative variation is employed to arrive at a composite, group structural description of how the participants as a group experience what they experience. The researcher integrates the textural and structural descriptions into a unified statement of the experience of the phenomenon as a whole (Moustakas, 1994).

It is a vivid, clear account of the universal character and dynamics of the experiences. The essential meanings are ideas that can account for the experiences of an

infinite number of individual manifestations. An interpretative synthesis consolidates the information (Creswell, 1998). The essential invariant structure is representative of a particular time and place and from the phenomenological vantage point of the particular researcher (Moustakas, 1994). Creswell (1998) recommends developing visual aids when possible; diagrams and tables assist readers with locating and identifying information as well as making for an organized system for retrieval of information (Creswell, 1998). Tables of categories and themes can serve as visual summaries of the data analysis.

QSR-N5: Computer Analysis Program

The data analysis program chosen for this phenomenological analysis was QSR N5 (Richard's, L., 2000; Richard's, T., 2000). QSR-N5 is the fifth revision of a product earlier known as NUD*IST: Non-numerical Unstructured Data Indexing Searching and Theorizing. These programs are tool-kits for analyzing and coding text documents in qualitative analysis; the interviews, transcripts and field notes that compose the data.

Qualitative data analysis requires interpreting data that are relatively unstructured and considered inappropriate to reduce to numbers. QSR-N5 does not replace the researcher in data analysis; rather, it organizes complex data in a way that allows for easy access of text documents (Richard's, L., 2000). Prior to these computer programs, the researcher manually organized large amounts of text, either by cutting and pasting small units of print or using color codes to do the same. QSR N5 shortens this lengthy process.

Data analysis in QSR-N5 begins with transcription of recorded data and field notes into a word processing program. After a project folder is created, interview data are imported in the form of text files; the latter makes analysis of text words possible in the

computer program. Each interview receives its own program file for separate analysis; later, interviews are analyzed as a whole for the purpose of creating collective categories and themes or the exhaustive description of the phenomenon.

Prior to importing a text file or interview document, parameters are set for breaking down text data. An asterisk is placed before each question and answer sequence for later analysis of speech exchanges and auto-coding; computer developed codes and themes, based on targeted text words, to ascertain degree of agreement between the computer and the researcher. (Richard's, T., 2000). Auto-coding facilitates objective verification of the themes and meanings derived.

There are three basic parts of a QSR-N5 project: documents, nodes, and the processes that link them (Richard's, T., 2000). Documents, discussed above, are analyzed by the unit chosen; lines, sentences, or paragraphs. In this browser, the window for working with a document, one can read the text, make memos or reports, or annotate and amend the document. Each unit is coded at a node. The node system is a container for ideas and coding about the meanings of text; a means of abstracting from the data. Nodes are akin to the categories or baskets for segments of text found in qualitative literature, that define or describe a text unit (Moustakas, 1994). The Node Browser performs all the functions of the Document Browser. Once a node is established with a title and description, the unit or units of text are coded at it (Richard's, L., 2000).

Two nodes exist in QSR-N5: free and tree nodes. A free node is akin to the initial categories discussed by Moustakas (1994). It is given a title and short description then logged in a scroll bar in the node window. These nodes are in view at all times on the computer screen. The memo and report areas allow one to begin writing reports in

narrative form which later are exported into the researcher's final document. Because each analysis step is logged with a time and data stamp, the researcher can keep track of the progression and evolution of ideas.

As the analysis progresses and free nodes accumulate, ideas begin to condense and free nodes are transferred into tree nodes. A tree node is a hierarchical accumulation of categories and ideas that allows for display of intertwining themes or patterns. Tree nodes aid in the development of themes and theories; nodes become sub-categories or other nodes or equally significant "sibling" nodes to each other (Richard's, L., 2000). As ideas develop, the program allows the researcher to merge nodes with similar content or create these hierarchical relations between nodes.

QSR-N5 has an annotation node. Annotations are a place for the researcher to keep her or his remarks and comments. They are placed immediately beneath the text units to which they apply and are used for the development of categories, themes, and theories on the material (Richard's, T., 2000). The annotation node for each document is the equivalent of writing notes on transcript margins when using the paper-and-pencil qualitative analysis format. They are a place to record observation or field notes or in-context reflections directly related to the preceding passages in the interview.

The data analysis proper is followed by an account of the experience for the researcher and each of the participants (Creswell, 1998). Moustakas (1994) recommends keeping field notes at all stages of the fieldwork; field notes include an evaluation report of the researcher's own experience, thoughts and feelings. Kvale (1996) recommends that the qualitative narrative retain the richness and complexity of the interview process.

Methods for Verification: Criteria for Trustworthiness

Naturalistic paradigms are criticized for being subjective and untrustworthy.

According to Lincoln and Guba (1985), unlike quantitative inquiry, issues of internal validity, external validity or generalizability, reliability, and objectivity assume different form and meaning in qualitative analyses; these concepts are reconceptualized into the postmodern, post-positivist terms of credibility, transferability, dependability, and confirmability, respectively; terms relevant to interview research, humanistic psychology, and the heterogeneous, contextual knowledge that help to establish the trustworthiness of qualitative research findings. According to Lincoln and Guba (1985), the truth value of a study is its applicability, consistency and neutrality.

External validity can be threatened by selection effects if constructs are specific to a single group or a particular context (Lincoln and Guba, 1985). Transferability is the qualitative counterpart to external validity and involves analytic generalization; the transfer of findings based upon an analysis of similarities and differences between the two situations (Kvale, 1996). Marshall and Rossman (1999) state that controlling the research is purposefully avoided to allow for the recording of social complexities with a flexible research design. Inter-subjective agreement enhances transferability of findings; when multiple observers agree on a phenomenon, their collective judgment is more objective (Lincoln and Guba, 1985). Research findings, however, remain specific to the time and context in which they were gained. Generalizations are dependent upon the degree of congruence between the sending and receiving contexts.

Lincoln and Guba (1985) suggest replacing the word internal validity with credibility. In quantitative research, objectivity and neutrality are important to avoid bias

and confounding of results. Objectivity in this sense cannot be achieved because the approach requires a level of familiarity and intimacy between the researcher and participants and consideration of the values of both parties. The credibility of findings is enhanced by building trust, sufficiently understanding participants and correcting misinformation and distortions through which the researcher gains a deeper level of understanding (Lincoln and Guba, 1985). Triangulation enhances credibility by bringing together multiple sources, investigators, or theories to bear on a single point and illuminate the research (Marshall and Rossman, 1999).

The confirmability and dependability of qualitative data are enhanced by an audit and a detailed paper-trail kept by the researcher; complete records of raw data, field notes, personal thoughts and hypotheses, all data from the analysis steps, notes about procedures, strategies, and designs, forms, schedules, and final reports (Lincoln and Guba, 1985). Trustworthiness is facilitated by checking that the findings are grounded in the data and verifying the appropriateness and explanatory power of category labels. Kvale (1996) recommends that analyzed impressions be returned to interviewees for clarification and verification. Verification emanates from the interviewer who is knowledgeable about the topic and human interactions.

According to Lincoln and Guba (1985), member checks allow participants an opportunity to correct errors and wrong interpretations, provide additional information, and summarize their thoughts and feelings about an experience. The close of each interview contain such a question. According to Moustakas (1994), verification is enhanced by returning to the research participants, sharing with them the derived meanings and essences from the interviews, and seeking their assessments of

comprehensiveness and accuracy. Lincoln and Guba (1985) consider member checks to be a crucial technique for establishing credibility because they test for interpretative accuracy. When research participants review the data, they can confirm or alter it to correspond to their perception of reality.

Application of Qualitative Research Procedures in the Current Analysis

Choosing Qualitative Inquiry

Because the purpose of the current analysis was to explore and describe the meanings and impact of managed behavioral health care on the process and perceived outcome of psychotherapy for private-practicing psychotherapists, a qualitative design facilitated an understanding of the professional's personal perspectives. The research questions suggested a qualitative exploration because the techniques seek to understand what is occurring and by what processes, managed behavioral health care impacts psychotherapy in these settings (Creswell, 1998).

Due to the limited understanding about the effects of managed care on the private outpatient psychotherapist, qualitative analysis offered the best methodological approach for gaining detailed viewpoints of practitioners themselves, devoid of research-imposed restrictions on topics, themes, and variables explored. Qualitative inquiry facilitated the development of holistic, complex descriptions of this phenomenon. As Moustakas (1994) suggests, preconceived experimental designs impose and restrict constructions of the full meaning and complexity of human behavior.

Currently, there is a paucity of traditional or innovative empirical research regarding the impact of managed behavioral health care on the processes and perceived outcomes of psychotherapy. This is partially due to the inability to identify relevant variables for analysis and the lack of theories to explain psychotherapist's behavior in a managed care environment. The literature that is available advances the personal opinions of practitioners and the perspectives and agendas of managed care corporations.

Through the process of developing a detailed view of the issues, this qualitative inquiry initiated the process of understanding and exploring core issues, experiences and concerns by examining the subjective and multiple realities of the participants directly involved. The data analysis, interpretations, and recommendations serve as a guide to policy-makers, practitioners, academicians and trainees in ensuring that clients are most productively serviced. Effective, quality mental health care suggested the need to understand any potentially relevant processes from the deliverers of care.

The phenomenological approach was indicated in this study because of the need to develop common an understanding of consensual themes across professionals who practice psychotherapy within the context of managed behavioral health care. The available literature has been focused on inpatient treatment modalities. There is a paucity of literature about non-acute and chronic cases, personality disorders, long-term care and sub-clinical populations that do not require inpatient services. Issues relevant to the process of psychotherapy within the context of managed care can be adequately addressed only when practitioner's experiences are understood relative to what is already known about the process and outcome variables effecting psychotherapy.

Population, Participants, and Sampling Procedures

Because it is essential to a phenomenological study that all participants have experienced the phenomenon, criterion sampling and maximum variation sampling served as the purposeful sampling strategies in this study. Criterion sampling was defined as licensed professional psychotherapists, with five or more years experience whose primary professional role took place in a private practice setting. The research focused on cross-site and cross-discipline analyses to enhance the transferability to the findings, provide for reasonable variation of the topic or phenomenon, and maximize comparison of a range of perspectives (Marshall & Rossman, 1999).

Psychotherapists were not restricted to one field of training or professional affiliation because of the desire to examine and explore issues between professional fields. A primary professional role in the private practice setting was defined as a psychotherapist whose spends at least 50% of their professional time in private practice. The criteria of a minimum of five years post-licensing experience was chosen to help ensure that participants will have had exposure to the phenomenon of working both with managed behavioral health care insurance and the more traditional medical indemnity insurance; plans that pre-dated the HMO era and did not requires the active involvement of the insurance company in treatment plan decisions (Moustakas, 1994).

By 1995, over 20% of individuals with health insurance received it through managed care plans (Anders, 1996). Thus, five years of post-licensing clinical experience helped ensure adequate understanding of insurance and clinical skill development. It was advantageous to have individuals who understood the disadvantages and advantages of

both general forms of insurance participation thus enabling them to provide more detailed descriptions of the experience of working with managed behavioral health care.

This researcher wanted to obtain information across disciplines and enhance transferability of the findings. Thus, initial participants were chosen to from each of the professions who meet sampling criteria and were licensed to conduct private, outpatient psychotherapy: psychology, psychiatry, social work, and nurse practitioners. Professional and academic affiliations generated the participants. The researcher had contact with and affiliates in 15 medical institutions in New Jersey. Referrals through these contacts were used to attain the interviewees. Due to the evolving nature of qualitative design, the number of participants could not be delineated prior to the study. Interviewing continued until redundant information was obtained; a total of six in-depth interviews were completed. Table 1 includes the demographic data for the participants in this study.

Table 1

Interviewee Demographic Data

| Case | Gender | Age Group | Years Practicing | Discipline |
|-------------|--------|-----------|------------------|-----------------------------|
| Therapist A | Male | 50-59 | 28 | Psychiatry |
| Therapist B | Female | 40-49 | 21 | Social Work |
| Therapist C | Male | 50-59 | 25 | Psychiatry/Psychology |
| Therapist D | Male | 40-49 | 16 | Psychology |
| Therapist E | Female | 50-59 | 15 | Social Work/Nurse Counselor |
| Therapist F | Female | 50-59 | 15 | Psychology/Nurse Counselor |

Setting

A natural setting or context was chosen to enhance the relevance and pertinence of the obtained data. In this study, by contextually studying psychotherapists in the environment in which they conduct their professional roles, they were freer and more comfortable to explore and express their opinions, feelings, beliefs, and thoughts about managed behavioral health care and its impact on the process of psychotherapy.

The private offices in which participant practitioners conduct their actual therapy sessions was deemed appropriate and necessary for obtaining honest, candid and direct responses to inquiry questions. It was also foreseen that this setting was the best avenue for triggering relevant clinical material; by having participants construct and discuss their experiences in the actual physical space where issues relevant to a managed behavioral health care environment are most often construed. This researcher traveled to participant's private offices to conduct the interviews.

Entry, Access, and Rapport

In an effort to initiate access, rapport and entry, initial contact occurred via telephone in which a standard introduction initiated discussion about the purpose of the investigation and volunteering (see Appendix A). Potential participants were screened during this call for meeting the criteria for inclusion. Questions and concerns from the participants were addressed; the information from these conversations was recorded on computer files and coded names anonymously for future reference.

If initial consent was obtained and the potential participant met sampling criteria, an appointment date and time was scheduled for the actual interview. Participants were

advised that the consent for participation form would be signed and copied at the time of the interview. The personal telephone afforded participants the chance to ask questions regarding the study thus facilitating trust and openness through honesty and disclosure.

A number of rapport techniques were employed throughout the interviews and ensuing conversations with participants. Empathic listening facilitated obtaining truthful knowledge about participant's experiences regarding the impact of managed behavioral health care on how they conducted psychotherapy. Second, whenever possible, questions were open-ended to facilitate exploration of meanings. These questions took the form of the following: Could you tell me, How does, What is the, Tell me what happened, Do I understand you correctly when you say etc.

Entry, access, and rapport are related to the ethical issues of confidentiality, informed consent, privacy, protection from harm, freedom to withdraw from the study, and addressing negative effects for the participants. These issues were addressed in the consent form in which care had been taken to assure subjects that confidentiality would be maintained. The history of managed care imposed penalties toward individuals who disclose negative statements about managed care, necessitated that a reliable contract of anonymity be made available to the professionals who contributed to this study. Though the topic of managed care can be an emotional one, therapeutic and emotional issues during the interview took a minimal role; the professional nature of the topic, though close to home for many participants, did not cause emotional distress.

A briefing before the interviews and a debriefing afterward also facilitated access and entry into participant's lived experiences; both techniques were related to researcher disclosure. Through openly, discussing the situation, purposes, goals, and significance of

the study, the use of recorders, limitations of the research, confidentiality, and offering time for questioning, participants were helped to feel comfortable to honestly reveal their experiences about the topic. Reciprocity was addressed by acknowledging and validating the importance of their participation for this work. Questions that went beyond issues relevant to facilitating open, in-depth disclosure were addressed after the interviews.

Questions about the researcher, and self-disclosure, were handled similarly: interviewer's questions were addressed sufficiently to enhance the atmosphere is trust and openness. However, no information that suggested favoring one position or opinion was provided to interviewees, thus avoiding biasing responses or curtailing the level of disclosure about issues. This researcher's experience conducting interviews and therapy helped to heighten awareness for the nuances of entering relationships, respecting participant's concerns, and facilitating the rapport necessary for full, deep disclosures.

Personal Biography and the Role of the Researcher

In this study, this researcher conducted the interviews. The credibility of the information and interview process was enhanced through a number of relevant training and professional experiences of the researcher. First, this researcher has been employed for 11 years in a job which relies solely on semi-structured interviews; psychiatric, crisis emergency interventions. Second, this researcher works with managed behavioral health care on a daily basis, both with initial treatment authorizations and continuation of care approvals, allowing the development of a substantial knowledge base about the intricacies of this part of the health insurance system. Third, academic training has included three years of interviewing experience internship sites.

Marshall and Rossman (1999) also advocate for researcher competence when conducting qualitative analyses; the researcher is capable of employing the methods and interested enough to complete the project. Discussion of personal biography and biases is related to the concept of Epoche or bracketing in Husserl's phenomenological inquiry. In it, the researcher understands and writes a full description of her or his own experience with the phenomenon, thereby bracketing these experiences from those of the participants. Bracketing personal beliefs, experiences, and feelings about the topic is a prerequisite for enabling individuals to fully explore personal ideas and express personal opinions without fear of repercussion. Self-examination allows the researcher to gain clarity on her or his own preconceptions (Marshall and Rossman, 1999).

Like many professionals, this researcher has struggled to obtain treatment approvals, has been frustrated in attempts to obtain medical necessity criteria, or be provided with the clinical reasons for treatment denials. This researcher experienced the containment of financial abuses that occurs in both the medical and mental health areas of treatment. However, the review of the literature facilitated a change of opinion for this researcher, from a negative one of managed care toward a more neutral one; managed care not only staves-off fraudulent practices of practitioners, it encourages the development of richer, more effective therapy techniques and approaches as well as the therapist's attention to process details and client change during the treatment process. Though this researcher phenomenological history cannot be completely suspended during the inquiry, the data were analyzed to verify that personal bias had not unduly affected data collection. The interview transcripts verified that questioning was open-ended, neutral, and facilitating, enhancing an objective analysis of interview data.

Data Recording Procedures

Verbal material was the primary data collected throughout this study because the goal of the study was a detailed understanding of the experience of managed behavioral health care and its impacts for the process of psychotherapy for individual therapists. In addition, behavioral observations and field notes made during and after the interviews constituted secondary data sources. The collection of documents, i.e. insurance papers, behavioral health certification and re-certification forms, from the participants was not attempted as these materials are confidential to the therapeutic relationship and are difficult to attain. Generic documents or letters were requested for analysis.

After securing written consent from the interviewees (see Appendix B), the interviews commenced and tape-recorded. The instructions to be given to participants are detailed in the protocol form (see Appendix C). The recording of the interviews was done with two high-sensitivity audio-tape machines, to ensure the adequacy of data collection and protect against technical faults. Lincoln and Guba (1985) define the fidelity of the data recording mode as the researcher's ability to later reproduce the data as it became evident during the investigation. Audio recording assured this as a complete data source.

Tape recording cannot capture the visual aspects of a situation, a setting, or facial and bodily expressions of interviewees (Kvale, 1996). Though video recording would provide a record of nonverbal data, it may have prevented participants from being candid because of the loss of anonymity. Audio-taping can also be perceived as intrusive but was chosen to maintain anonymity and allow for freer flowing dialogue. Because of the need

to record behavioral observations, a protocol was included to record field-notes and pertinent non-verbal material (Kirk & Miller, 1986, in Kvale, 1996).

Field notes systematically record events, body language, affects, behaviors, and objects in the social setting chosen for study (Marshall and Rossman, 1999). Because note-taking might disrupt the conversation, all efforts were made to leave recorder out of the direct eye gaze of participants and to minimize note-taking during the interviews, taking them immediately post-interview instead. The interview guide also had space to record comments on verbal responses and the researchers thoughts and reactions. Interview interactions consist of a steady flow of nonverbal communication clues (Creswell, 1998). Impressions from these interactions add meaning to spoken words, give attitudes and actions additional meaning, and help to reveal unconscious thoughts essential to accurately decoding situations (Marshall and Rossman, 1999).

The initial page of the interview guide included descriptive notes (the time, date and place of the interview, and names), descriptions of the subjects, physical setting, events and activities, and any noteworthy dialogue. The information obtained, from the initial telephone conversation in response to the request for participation was included at the top area of the first page of this form. Each page was divided in half for descriptive and reflective notes (Creswell, 1998); information relevant to participants responses and the researchers thoughts, impressions. The benefit of using the protocol outweighed any drawbacks; the sole use of an audio-recording warranted an additional avenue for recording relevant visual material and thoughts easily forgotten. Note-taking is also useful in the event that the recording equipment fails (Creswell, 1998).

Data Collection Procedures

In the present analysis, in-depth interviews were chosen as the data collection method because they afford a degree of control over the interview process. The sensitive nature of the subject matter directed the inquiry toward interviews because of the privacy afforded participants regarding disclosure of experiences and opinions about managed behavioral health care. In-depth, semi-structured one-on-one interviewing facilitated discussion of topics that professionals have, hitherto, been penalized for discussing.

Kvale (1996) defines semi-structured interviews as having "a sequence of themes to be covered, as well as suggested questions. Yet at the same time there is an openness to changes of sequence and forms of questions in order to follow up the answers given" (p. 124). The privacy of the interview enabled participants to freely discuss issues related to their personal experience and meaning. Surveys and questionnaires were not employed for two reasons: no specific measures on the topic have been developed and cannot examine complex relationships and intricate patterns of interaction.

The interview guide is included in Appendix C and includes the initial interview questions used to facilitate participant's exploration of the themes. The questions helped systematize questions across subjects and assisted participants with exploring themes. This semi-structured design provided direction while allowing interviewees latitude to explore experiences and perspectives without prompting. The questions were non-directional, to avoid imposing strict direction on what material is explored.

Prior to initiating the interviews, participants signed a copy of the participant consent form which includes and discusses the following information: request for voluntary participation in the study, sampling criteria, the purpose of the study, relevant

data collection procedures, confidentiality and anonymity, offering copies of results, risks and benefits of participation, audio-recording of interviews, and reciprocity issues concerning the importance of participant's involvement in the study.

The participant consent form addressed the ethical issues of informed consent, confidentiality, and consequences. Informed consent was critical to ensuring that the study was ethically conducted (Marshall & Rossman, 1999). The form reassured participants that their anonymity would be maintained throughout the study. Because the audio-tapes will be retained for one year and to assure maintenance of data, reference to identifying information was dubbed with a pseudonym; each participant was referred to as "Therapist (alphabetical letter)." Also, references to organizations or persons were dubbed with pseudonyms to protect identification from readers of the final manuscript.

Informed consent was also facilitated through the explanatory passage on the written consent form, in which subjects are briefly told about the nature of the research study. According to Kvale (1996), the qualitative researcher must strike a balance between providing overly-detailed information and withholding aspects of the design that may be significant to subjects. There was no attempt at deception of the research, as this was not deemed necessary to help individuals explore their own personal world views about the topic. The consent form addressed main features of the design, potential risks and benefits, the voluntary nature of the study and absolute right to withdraw at any time.

Data Management Procedures

In accordance with the Constant Comparative Method and Moustakas' (1994) Transcendental Phenomenological Approach, each interview was transcribed onto computer file and analyzed immediately after it occurred. The dependability or reliability of the interviews was addressed by transcribing tapes verbatim. According to Kvale (1996), "Transcripts are decontextualized conversations" (p. 165) and can create an artificial construction of an inter-relational event. Therefore, transcriptions included all pauses, repetitions, reference to tone of voice when relevant, non-words, exacerbation, and other disruptions of speech not normally seen in written prose. The accompanying log and field notes supplemented the verbal transcription to provide an even more realistic description of the interview in context.

Detailed descriptions of the subjects and the contexts in which they work were obtained during the interviews and included in the computer files via field notes. New questions emerging in each interview were addressed in later interviews by adding questions to the guide. Topics or issues, seen as irrelevant following a number of interviews, were eliminated or altered. By definition, qualitative inquiry is inductive and this study followed the direction of thought which subjects found phenomenologically relevant. Field notes and reflective thoughts were recorded immediately after each interview, on the guide, and imported into the computer files as soon as was possible.

Following completion of the interview, participants were thanked for their participation in the study and their anonymity again assured. Participants were afforded time to ask any questions or concerns that arose from of the interview process. The following standard question was posed to each participant: "I have no further questions.

Do you have anything more you want to bring up, or ask about, before we finish the interview?" Kvale (1996) discusses debriefing as a time to address tension and anxiety about having exposed personal information and emotional experiences, to address detailed concerns about the purpose of the investigation, to address any feelings of emptiness about having unilaterally disclosed information, and to address any positive experiences that have occurred from the interview.

Because of the need to return to participants for verification of analyzed material, the debriefing cautiously disclosed information to participants assure the integrity of information or data later obtained from them. The researcher gained consent to contact participants to obtain future information and ask further questions if needed. Questions or discussion arising after the recorder was turned off, when participants more material without a perceived need to censor, were noted in a log book of field notes.

Two field journals were kept (Lincoln and Guba, 1985). The first recorded the day to day activities related to the inquiry process, including methodological decisions related to the design of the inquiry. The second, a personal log, included the researcher's reflexive and introspective notes relative to what was happening in the field. These records added to the trustworthiness of the study by creating an ongoing trail of thoughts and decisions. Distortions and ineffective biases were more accurately examined, to assure a healthy amount of objectivity and neutrality during the study.

Upon completion of each interview, audio-tapes, protocol forms, field notes, and the logs of data were labeled with the pseudonym given to each participant; information associated with each therapist was inclusively labeled "Therapist (letter of the alphabet)." The reference connecting the pseudonym to the actual interviewee's name was privately

retained by the researcher in paper-and-pencil format, to avoid access to computer files by outsiders. Each interview was transcribed onto a file in Microsoft Word- Windows 98. Microsoft Word files were imported into the QSR-N5 program employed in this study. This is further outlined in the section about QSR-N5.

The information recorded on the protocol forms was also retained on computer files, again coded with the pseudonym to match each respective participant's interview transcription. All files were copied two additional times and printouts made of each transcription, protocol information, and researcher's notes, to assure that data was not lost. At each stage of the data analysis, this information was retained in appropriate data files: meanings of statements, themes derived, structures of themes and meanings.

All of the interviews were transcribed by the researcher to facilitate understanding about the quality and context of the recording, participant answers, the interviewer's technique, attentiveness to detail, and ability to ask relevant follow-up questions. Instructions to transcribers were eliminated from the design because others did not assist with transcription. Each interview was first read in full twice, immediately following its taping to allow maximum retention of contextual data. Any references to personal names, organizations, or identifiable details were deleted at this time.

Interview tapes were transcribed verbatim, including all repetitions, incomplete sentences, digressions, non-words, reference to tone of voice, to retain as much of the context of the conversations as possible and enable the reader to understand as much of the interviewee's intended meanings as possible. In psychological analysis, disruptions of speech can be relevant for later analysis. Pauses longer than 3 seconds will be noted as such in parenthetical notation; pauses longer than six seconds will be indicated by the

phrase long pause in the same notation. As Kvale (1996) states, "transcripts in isolation make an impoverished basis for interpretation" (p. 167). Therefore, observational data and field notes were recorded in separate computer files to facilitate comparison with audio recorded data for consistencies and contradictions. Kvale (1996) says "postmodern conceptions of knowledge emphasize the contextuality of meaning" (p. 168).

Data Analysis Procedures

Epoche or Bracketing.

In this study, this researcher believes the Epoche was achieved. A review of the questions posed during the interviews and during data transcription, did not reveal statements or questions laden with opinions toward managed care. Questions were primarily open-ended. In an effort to refrain from biasing participant answers, the review of the manuscripts revealed that some questions leaned toward the vague side and needed clarification to participants because of their neutrality and lack of clear direction. Any opinions expressed by this researcher came only toward the last two to five minutes of each interview, only after interviewee thoughts and apparent themes had been exhausted.

Significant Statements: Horizontalizing.

For this study, the post-interview analyses began with the verbatim transcriptions. Each transcript, and all observation and reflection notes, were typed in their entirety as close as possible to the actual recordings. The first interview was completed, with all initial questions and sub-questions asked and answered. Transcription of the audio-tape

was done and a printout of the interview made . Prior to coding each interview, the transcript was read twice, to develop a sense of its gestalt. Moustakas (1994) notes the importance of obtaining a sense of the whole of the text before breaking it down to find essential meanings. This process was followed for each completed interview.

Reflections on the transcripts, protocols, field and log notes, protocol form notes and behavioral observations were recorded on a distinct area of the computer files of each participant; impressions and descriptions of the interview situation and actions toward obtaining information were detailed as well. The overall contextual impressions and feelings that resulted from the full readings of the interview text were recorded in a memo file for this interview in narrative form. Every document and each node can have one memo. The document memo file was used to record this interviewer's objective reflections on what was said before, during, and after the interview, as well as to record field and observation notes for later analysis. Memo was chosen for these text passages, rather than the annotation node, to avoid having this researcher's impressions and feelings being coded with the other interview text. The data herein was extracted into the final report to provide a full description of the researcher's experience.

Chronological activities and impressions of the progression of the study were documented in a separate Microsoft Word file. These initial activities were designed to provide a general understanding and flavor for the interview data and began the process of summarizing reflections and notes (Creswell, 1998). The goal of this stage was to gain an sense of the data as a whole, participant by participant before breaking down interview data (Creswell, 1998).

QSR-N5 allows text to be broken down into lines, sentences or paragraphs. This part of the analysis partially satisfies the data reduction step in Moustakas' (1994) Transcendental Phenomenological Approach of Horizontalizing: text units are broken down into the smallest interpretable piece of information to be examined for meaning. The statements describe how individuals experience the topic in question. In addition, field notes, behavioral observations, and reflective notes, were added to each participant's computer document file in the memo section. This researcher is able to keep all data about a participant together yet separate from transcript content.

Sentence units were chosen as the unit of analysis to allow for coding of complete interviewee thoughts; it was felt that line by line analysis would disrupt a full thought. Analysis by paragraph might result in single analysis of multiple thoughts; if paragraphs needed to be coded in more than one place, inaccuracies would occur in data analysis. If an interview sentence consisted of more than one thought, it was initially coded in multiple places; duplications were later deleted during a second analysis of the coding. Organizing data became more manageable through use of the computer filing system.

Invariant Horizons: Meanings of Statements.

This part of the analysis satisfies the step in Moustakas' (1994) Transcendental Phenomenological Approach to data reduction of Horizontalizing and invariant horizons. Text units were broken down into the smallest understandable pieces of information and examined for their interpretation and meaning. They are pre-reflective description which are labeled for comparison with one another (Creswell, 1998). Moustakas (1994) adds that initial categories are formed by reflecting on the larger ideas presented in the data.

Moustakas (1994) warns against imposing one's own meanings onto categorical names to fit the researcher's point of view. To this end, as often as possible, category names were chosen using actual words employed by interviewees at that particular text passage. By doing so, this researcher was aided in performing the Epoche or bracketing of personal experience and preconceived ideas about the issues in question for the sake of mainly focusing on the personal experiences of the interviewees (Moustakas, 1994).

A category or node titled Base Node was developed to serve a number of functions. First, demographic data was contained there: gender, age, profession. Second, subsumed under this tree node were separate sections for each interviewee at which descriptive information about background and setting, and relevant notes were eventually added for later analysis and quantitative comparison of data.

Initially, the beginning of the analysis of the first interview with Therapist A was overwhelming; every sentence unit required a new node with a seemingly infinite number of categories or nodes developing. As suggested by Kvale (1996), the determination of a category name and the choice of where to place text units was aided by repeatedly asking the following questions: what does this statement tell me about the topic and what is the interviewee trying to say.

Themes of Meanings.

Upon completion of the initial coding of the interview, 125 free nodes existed. After a second reading of this interview, it appeared that a number of the free nodes overlapped with each other or were related to them. It became easy to see how QSR-N5 cut down on the time spent with coding; the computer files neatly hold all text material

and make it easily retrievable. A report was printed for each node which contained all of the text coded at that node, enabling one to see all relevant material coded there.

In the second step of analyzing the first interview, this researcher reviewed these reports to determine which nodes needed to be changed, combined, or deleted. As noted by Marshall and Rossman (1999), through coding, new ideas and themes emerge, necessitating changes in categories that are then recoded. Moustakas (1994) adds, "things become clearer as they are considered again and again" (p.93). This process occurred with each interview completed. It was here that the Method of Constant Comparison began. In it, data is repeatedly examined and verified to assure that essences and themes have been derived from them (Moustakas, 1994). Data analysis is cyclical and occurs simultaneously as data is gathered, transcribed, analyzed, and interpreted (Creswell, 1998; Kvale, 1996). There is constant recoding of observations as insights grow.

This process continued until modifications of themes and categories was no longer necessary and the relationship among critical categories were as integrated as possible (Marshall and Rossman, 1999). Creswell (1998) metaphor of a camera lens is definitive where the researcher pans out, zooms in, then pans out again. In QSR-N5, the Constant Comparative Method is referred to as "Coding On" (Richard's, L., 2000; Richard's, T., 2000); the researcher moves between text and coding categories and between coding categories. Gradually, the categories merge or become connected to one another in a tree diagram where some categories are subordinates to each other or categories equal to one another are assumed under one common heading. This process continues until saturated themes are developed, accounting for the majority of the data.

QSR-N5 allows the researcher to keep the complete contents of each interviewee separate while, at the same time, records each interview file in the same project folder so that coding and categories can accommodate and reflect all interviews involved in the data analysis (Richard's, L., 2000). This process facilitated the use of the method of constant comparison discussed above. It also facilitates Moustakas' (1994) Transcendental Phenomenological Analysis step of developing textural and structural descriptions for each interviewee and the composite descriptions for the group as a whole.

At this point in time, new questions were added to the interview protocol based on these clearer understandings; some questions were altered or deleted to reflect the topics addressed in the first interview and to follow-up on the relevancy of these new thoughts. Every above referenced change, addition, or deletion of codes was recorded in a memo for the resulting node, thereby allowing this researcher to maintain the on-going log of the development of ideas. Marshall and Rossman (1999) discuss the dialectical nature of data analysis; strategies are adjusted to emphasize the experiences bearing on the development of understanding. An annotation node was developed to record in-context thoughts about the text material itself. Marshall and Rossman's (1999) call this a deconstructive reading of the text: reading the material for unconscious assumptions.

The second interview was conducted, transcribed and coded. Where text units for the second interview were initially coded at more than one node, a second reading resulted in determination of the appropriate coding node or category. Some text units from the second interview were coded at categories developed in the first interview; other text units necessitated the development of new codes. Further, the descriptions and titles of some newly developed and already existing codes were merged or changed to reflect

deeper understanding of the content areas in question. Annotations and memos were developed with the second interview. The memos, related to each category or node in question, came to further reflect the progression of ideas related to coding of text units.

At the completion of the first interview, 125 free nodes existed; by the end of analysis of the second interview, the total number of nodes was reduced to 95; 55 free nodes and 12 tree node categories comprised of over 40 free node categories. Initial categories slowly merging. Constant Comparison resulted in the development of additional ideas and categories to be explored in the third interview. Additional questions were developed again. The new nodes, with accompanying transcript material from the first two interviews were printed to again mark the progression of theme development.

The third interview was conducted. It was transcribed, imported into the computer program and coded. The above procedures were followed for this interview text. During the coding process, more categories were combined and moved into tree nodes or major developing themes. These changes were recorded in the node reports for each node category. Some categories and themes continued to be prominent while other issues gained prominence through their relation to existing nodes or emerging themes.

The result was a number of alterations to the coding categories or nodes. Specifically, there now existed 14 tree nodes under which 82 free nodes were now accounted for. There remained 43 free nodes which were left free-standing until further interviewing would help to clarify their relation and position in the developing themes. Tentative textural and structural description were developed for the first three interviews in individual narratives. This step was taken at this point in time because categories and meanings did not seem sufficiently clear after the first or second interview to do this; after

the third interview, clarification of category descriptions and meanings seemed developed enough to clearly define each of the first three interviewee's experiences.

The three interviews that followed were completed, transcribed, coded and recoded as outlined above. Following completion of the fifth interview, it appeared that categories were saturated because no additional nodes or category labels were being developed. The sixth interview was completed as a safety measure to validate this. The fourth and fifth interviews did not suggest the need to develop new questions for the subsequent interviews; participants were spontaneously discussing material that answered both the original and later developed interview questions. Participant six answered interview questions with material similar to those of the previous interviewees.

The process of moving free nodes into tree nodes occurred as follows. Each free node was examined for its content following which the existing tree node data was viewed for comparisons and contradictions. Nodes or categories that were similar in content were grouped together under relevant tree nodes. Free nodes not already related to tree nodes were grouped together into newly developed tree nodes when appropriate.

At that point in the analysis. A total of 138 free nodes had been grouped into 11 thematic categories. Each tree node, and the free nodes and transcribed data coded at it, was printed, clipped together, and placed in a pile for further viewing. By viewing the nodes, interview data and grouped material therein, these 11 categories were combined into the final seven categories that made up the final seven themes that emerged in this study. Time was spent viewing the final seven themes for the possibility of further combining them; however, the material was too diverse to merge these themes.

Individual Textural and Structural Descriptions.

Individual textural and structural description of these interviews was done following each transcription, reading, and analysis. The codes and categories became sufficiently developed that each narrative could be written with clear understanding of each participant's experience of managed behavioral health care. Individual narrative descriptions were done sequentially and prior to the development of the composite textural and structural descriptions to prevent contamination of individual experiences with a different conceptualization resulting from a composite view of the data.

The final individual textual and structural narratives were completed. Individual narratives emerged from viewing the printouts of each category or node along with the transcribed material subsumed under each theme. Table 1 shows the summary data which initiated the narratives. The first column contains the names of each major category and the related node subsumed under it. The remaining columns refer to each participant with the intercepting number reflecting the number of sentence or text units coded at that particular category for each interviewee.

For each participant, prominent coding themes or categories emerge from the data. From them, the individual textural and structural descriptions were developed. The printouts of the text coded at each thematic category, for each interviewee separately, provided the verbatim quotes used in the narratives. All quotations kept the anonymity of interviewees, persons and organizations mentioned. Quotations facilitate a deeper understanding of the nature of statements made for both researcher and readers of the narrative report (Kvale, 1996).

Composite Textural Description: Exhaustive Description of Phenomenon.

The final group textual and structural narratives were completed. These too were completed from the printouts of the group categories or themes that included the complete or total transcribed material subsumed under each theme. The composite descriptions developed like the individual ones: each theme's contents were read to gain a clear understanding of the common focus among the interviewees and numerous quotations from the participants used to enhance the qualitative validity of the ideas. Quotations from multiple participants lend support to a theme and enhance issues of reliability. Though the written text, quotes, and passages may appear less intelligible or articulate, the inclusion of verbatim material reintroduces as much of the context of the prose and setting as possible, allowing the reader to verify the emergent themes and more fully understand the meaning of subject's stories.

Member Checks.

Member checks were completed by all participants to help ensure the credibility of the themes and essential meanings derived in the study. By allowing different subjects to examine findings and interpretations, something akin to convergent validity occurs: each interviewee validates the reliability of the claims posed by the researcher. The researcher can then reformulate meanings until themes are accounted for and interpretations accurate reflect reality (Lincoln and Guba, 1985).

The individual textural and structural descriptions, in narrative form, were given to each of the participants involved in this study for their verification. In this manner, the themes developed for each person and, by implication for the entire study, could be

verified. Appendix D includes a copy of the cover letter sent to the participants, asking for their input on the content of the material.

At this time of this writing, four members have telephoned back. Therapist B, C, and F have assented that the narratives were satisfactory; although Therapist C commented on the length of the summary. Therapist A requested a change in one quotation included in his narrative; he added a one word extension making the content refer to a specific subset of rather than the entire group. Replaying his audio-tape revealed that the original transcript was accurate; however, to validate his phenomenological experience of the data, the sentence was changed to reflect the newer formulation. Telephone calls continue to be made to Therapist's D and E for input.

CHAPTER IV

Findings and Presentation of Data

Participant's Account of the Experience

Table 2 summarizes category development and the codes or categories used to write the individual and group textural and structural descriptions.

Table 2

Coding and Category Data

| Category or Node | Therapist A | Therapist B | Therapist C | Therapist D | Therapist E | Therapist F | Totals |
|-------------------------------------|-------------|-------------|-------------|-------------|-------------|-------------|--------|
| 1 MC*: Policy and Procedures | | | | | | | |
| Time Lost to Authorizations | 15 | 30 | 42 | 38 | 9 | 15 | 149 |
| Paperwork and Phone Calls | 2 | 18 | 2 | 0 | 0 | 13 | 35 |
| Justify to Unqualified Persons | 13 | 53 | 25 | 6 | 32 | 15 | 144 |
| Refusal to use Diagnostic Labels | 18 | 20 | 10 | 0 | 13 | 77 | 138 |
| Basis of Authorization Criteria | 3 | 16 | 19 | 10 | 0 | 0 | 48 |
| Positive Aspects: Treatment Plan | 1 | 0 | 19 | 1 | 9 | 0 | 30 |
| Drawbacks of MC Panels | 6 | 16 | 0 | 2 | 0 | 10 | 34 |
| Totals | 58 | 153 | 117 | 57 | 63 | 130 | 578 |
| 2 Monetary/Financial Issues | | | | | | | |
| Reimbursements Fees | 29 | 13 | 25 | 2 | 14 | 34 | 117 |
| MC Failures to Reimburse | 0 | 0 | 19 | 24 | 0 | 0 | 43 |
| Dollar-Driven Bureaucracy | 11 | 16 | 39 | 3 | 10 | 32 | 111 |
| Saving Tactics: Medications | 20 | 0 | 6 | 0 | 18 | 20 | 64 |
| Income Reduced | 28 | 10 | 6 | 15 | 20 | 3 | 82 |
| Totals | 88 | 39 | 95 | 44 | 62 | 89 | 417 |
| 3 Treatment Process Effects | | | | | | | |
| Therapy Relationship | 25 | 17 | 4 | 23 | 32 | 0 | 101 |
| Assessment/Conceptualization | 16 | 49 | 36 | 0 | 44 | 15 | 160 |
| Approaches and Techniques | 23 | 25 | 3 | 14 | 45 | 8 | 118 |
| Treatment Goals | 2 | 5 | 10 | 0 | 4 | 0 | 21 |
| Short-Term Therapy: Crisis Model | 10 | 41 | 35 | 12 | 0 | 10 | 108 |
| Pressure to use Short-Term | 27 | 15 | 8 | 2 | 0 | 15 | 67 |
| EVT/EST | 9 | 0 | 7 | 16 | 18 | 0 | 50 |
| Long-Term Therapy: Insight/Depth | 50 | 14 | 13 | 36 | 17 | 3 | 133 |
| Totals | 162 | 166 | 116 | 103 | 160 | 51 | 758 |

Table 2: Continued

| | | | | | | | |
|-------------------------------------|-----|----|-----|-----|-----|----|-----|
| 4 Effects on the Therapist | | | | | | | |
| MC Fees: Case Load/ Session Time | 47 | 22 | 0 | 0 | 9 | 1 | 79 |
| Emotional Availability/Distracted | 87 | 0 | 56 | 13 | 21 | 4 | 181 |
| Fear of MC | 12 | 0 | 6 | 0 | 0 | 0 | 18 |
| Ethical Concerns | | | | | | | |
| Allegiance Issues/Triangulation | 23 | 0 | 31 | 3 | 8 | 0 | 65 |
| Confidentiality/Privacy | 5 | 25 | 17 | 65 | 26 | 25 | 163 |
| Informed Consent/Deception | 0 | 20 | 5 | 53 | 16 | 14 | 108 |
| Therapist Autonomy | 0 | 0 | 20 | 4 | 0 | 12 | 36 |
| Totals | 174 | 67 | 135 | 138 | 80 | 56 | 650 |
| 5 Effects on Patients | | | | | | | |
| Patient Investment: Co-Payments | 33 | 27 | 16 | 35 | 0 | 10 | 121 |
| Fuel Resistance | 0 | 11 | 11 | 29 | 0 | 0 | 51 |
| Quality of Care Issues | | | | | | | |
| Declining Quality of Care | 25 | 13 | 18 | 32 | 2 | 38 | 128 |
| Long-Term Negative Effects | 22 | 7 | 30 | 5 | 0 | 22 | 86 |
| MC Therapist: Therapy Failures | 69 | 2 | 11 | 0 | 32 | 0 | 114 |
| Training Quality | 79 | 0 | 12 | 11 | 0 | 0 | 102 |
| Care Denials/Therapy Delays | 0 | 5 | 75 | 2 | 0 | 0 | 82 |
| Totals | 228 | 65 | 173 | 114 | 34 | 70 | 684 |
| 6 Therapist Responses to MC | | | | | | | |
| Avoid MC Systems | 42 | 24 | 43 | 28 | 20 | 17 | 174 |
| Negative Descriptors of MC | 22 | 3 | 14 | 17 | 2 | 15 | 73 |
| Refer MC Pts In-Network | 11 | 3 | 4 | 0 | 12 | 0 | 30 |
| Bypass MC Insurance | 8 | 10 | 0 | 42 | 7 | 13 | 80 |
| Manipulate MC System | 3 | 24 | 22 | 0 | 96 | 10 | 155 |
| Charting Strategies | 28 | 16 | 26 | 8 | 13 | 22 | 113 |
| Totals | 114 | 80 | 109 | 95 | 150 | 77 | 625 |
| 7 Changing the MC System | | | | | | | |
| MC Positive Effects | 0 | 0 | 21 | 0 | 0 | 5 | 26 |
| Accountability and Abuses | 17 | 18 | 5 | 9 | 6 | 20 | 75 |
| Treatment Accessibility | 0 | 11 | 11 | 4 | 14 | 6 | 46 |
| Higher Co-Pay: Higher Investment | 18 | 0 | 10 | 26 | 11 | 22 | 87 |
| Modify System | 18 | 13 | 18 | 0 | 17 | 16 | 82 |
| Collapsing health Care System | 18 | 0 | 17 | 0 | 0 | 0 | 35 |
| Legal Issues | 8 | 0 | 30 | 24 | 0 | 0 | 62 |
| Appeals of Care Denials | 0 | 0 | 21 | 8 | 0 | 0 | 29 |
| Patient Confidentiality/Privacy | 0 | 0 | 0 | 50 | 1 | 0 | 51 |
| Totals | 79 | 42 | 133 | 121 | 49 | 69 | 493 |
| * Managed Care is denoted as MC | | | | | | | |

Therapist A: Textural and Structural Description

Therapist A is a 55 year old male, conducting psychotherapy in private practice for 28 years, who remains affiliated with a number of hospitals. He is a psychiatrist who received a number of years of training in psychodynamic and psychoanalytic therapy. Though a psychiatrist, Therapist A's practice consists primarily of therapy patients; he does not focus on treating individuals solely with medication. The clientele of his practice is eclectic: patients range in age from adolescents to elderly adults.

The physical setting in which Therapist A practices was unique relative to the other interviewees. He practices out of a large house used solely for therapy work by himself and three other part-time psychotherapists. The physical layout of the house has not been altered from its appearance and past use as a family home. There is a large waiting (living) room lined with couches and tables; paintings and pictures adorn its walls, primarily couples romantically or lovingly engaged. His office is furnished with two leather couches and a chaise lounge chair for himself. Numerous pictures, statues, and drawings of human figures decorate the walls. The office manager's office is similarly adorned, with the addition of numerous filled book shelves.

It was consistent with the physical appearance of the office that, upon entering the house, I was greeted in the waiting room by the office manager who offered a beverage. I was led to join her in the kitchen. The office manager continued to make small conversation with me until Therapist A was ready to begin the interview. The poignancy of this encounter reflects the overall warmth created in this therapy office, from the setting and decorations to the interactions with the individuals working therein.

A primary theme emerging from this interview involved the thought processes of this therapist during therapy sessions, when he works with client with managed care.

Therapist A discussed the following related issues and concerns: distraction from the therapeutic relationship related to the need to justify sessions, ethical conflicts between allegiance to clients and insurance companies, and a resultant lack of accessibility with patients due to both. Distraction weighed heavily for Therapist A who said,

“If I have to worry about what is going to get them compensated, I am spending too little time in trying to get them well...It is an incredible distraction to have to justify what you are doing...Part of my thinking and part of my note-taking would be designed to justify, to be able to answer those questions later, when I have to fill out the forms to justify more sessions and document it in the chart rather than...to try to crane to hear what my patient is saying.”

Therapist A extended this concern to his colleagues. He added, “They are distracted. They are encumbered. I have so much freedom they do not have, to stop and really pay attention and concentrate on the person in front of me and what is really going on.”

The distraction stemmed from issues of conflictual allegiance and fiduciary responsibility. For Therapist A, his sole financial and emotional allegiance needs to be to his client. With traditional or fee-for-service insurance plans or self-paying patients, he found it easy to align himself only with his patient; no conflict of interest existed. He said, “If I charge the patient, then my allegiance has to be to the patient. I have to listen only to the patient...If it is managed care, then I have to live within a whole bunch of their rules and regulations...I was trained to believe, to know, that my fiduciary responsibility was only to my patient and my patient was responsible to pay my bill.”

Therapist A finds that his thought processes are compromised during sessions when managed care is involved. He believes time should be spent empathizing and

connecting to the patient rather than being concerned about what needs to be reported on managed care paperwork; the need to justify sessions and the resultant triangle of allegiance lead him to be distracted. Therapist A was very vocal on this issue, stating, "I have to ask for a visit...I have to justify three more. I have to do it in a way that they like. I have to spend the time figuring how to structure therapy in a way they will in fact compensate." The connection between justifying therapy sessions and the resultant distraction is clear in this and the following quotation regarding his clients:

"I work for them. I am their doctor. You can't do that in managed care. It is the need. Whose need am I looking to fill. Am I looking to justify to the company or am I really trying to understand the patient.. It is really difficult if not impossible to do both. You can't serve those two masters and serve them fully. All of us are distracted that are providing managed care, by this other master we have to serve"

Therapist A's anger about this conflict relates to an ethical conviction that the patient should be the sole benefactor of psychotherapy whose goal is to fully understand and assist clients in attaining mental health. His conviction was conveyed when he said, "We were a team. Me and the patient; the patient and me. The way it is now. I am split. I want to provide care for the patient but I also owe something to whoever is paying my bill. And, they have a right to impose certain things." There is a conflictual allegiance between patients and managed care because the primary payer of therapy defines to whom allegiance lies; with managed care in this role, it is difficult to align with patients.

The distraction prompted by the triangulated allegiance leads to a decrease in emotional and physical accessibility to all clients. Therapist A stated,

"I limit the amount that I carry and try to be a doctor to my patients...Anywhere I have to justify or anywhere I have to lower my fees, that means either I have to take on more cases or it means that I have to provide less service to the cases that I have. Every time I take on a managed care case, it effects my entire practice. It means more time devoted to the paperwork...It is less availability to the patient."

Therapist A believes colleagues working on managed care panels are in the same position. He says, "They really cannot keep up with their chart-work, paperwork, and their patients. They are just not emotionally available the same way they were. They cannot be." Physical accessibility declines because of time constraints from paperwork and phone calls. The therapist, becomes drained, unable to give emotionally.

As a result, Therapist A believes that clients serviced by managed care insurers, as well as non-managed care clients are adversely effected because the therapist is not fully accessible and patients with managed care insurance are no longer as invested in the therapy process. Therapist A has noticed decline in patient's efforts in therapy. He stated, "All they are concerned about is what can I get for my fifteen dollars. And they really, when they come to therapy, do not particularly work as hard. There has to be a much higher co-pay so there is more of an investment in the process." He believes that clients work harder for things in which they have a monetary investment. Small co-payments in managed care plans makes it easier to invest less of one's emotional self in the process.

The theme of declining quality of care in outpatient therapy took precedence for him. His thoughts focused on the declining efforts of the psychotherapists working with managed care. He gave an example of a patient experiencing a major depressive episode following the death of her mother and a diagnosis of breast cancer. The managed care-affiliated psychiatrist saw her every two to three weeks, primarily for medication management. Despite an increase of depressive symptoms, the treatment plan was not altered. When the psychiatrist became aware that her insurance had an out-of-network

option with more extensive benefits, the former developed a more intense treatment plan with full therapy sessions. Angry at the change, the patient changed practitioners.

This example highlights what Therapist A believes are the adverse effects on all health care consumers. He says, "I do not think they really get what they could. That they have the undivided attention of the person that is in front of them." Therapist A says that patients "are not getting care. I do not think they get cured as well. I do not think they get healed as well... Unless you help somebody develop better tools to deal with pressure, then they are always prone."

Therapist A further reflected on this idea of "managed care psychotherapy:" it is brief, symptom focused, crisis-oriented with little time to develop insights and change maladaptive personality and behavior patterns. Patient in such therapy are assessed too quickly and treatment plans are behaviorally-oriented. Therapist A believes managed behavioral health insurers prefer that patients be treated with medication only rather than "good old-fashioned psychotherapy:" medication management was "cheaper" and "shorter" in terms of length of care provided. Patients "are not getting the quality care. Because they are really not dealing with healers. They are dealing with business people who are trying in a business fashion to provide some healing." Therapist A related this problem to the allegiance issues discussed above.

A prominent emerging theme involved the notion of managed care as a "dollar-driven" business restricting care through profit-enhancing activities. He said, "It is all dollar-driven; completely dollar-driven. There is no concern for the providers or for the patients, none... They want to pay as little as possible. It is a business. I think they do not understand what the cost is to them. The American public... It is much more a business."

This theme was related to a focus on the fees the professional received within the current managed care environment and the resultant inability to make a living; he connected both issues to the declining quality of care and the therapist's inability to be accessible to patients. Therapist A says, "You have to start compromising. How do you compromise? You take on more patients. You squeeze them a little more. You take off more time. It is a business where doctors work for the business and...have to be allegiant not to their patients but to the business."

Surviving in a managed care environment means shortening session length and increasing case loads because of capitation: managed care pays a flat amount per patient regardless of session length. He added, "I have peers, they get the same compensation whether they see them for six minutes, eight minutes, fifteen minutes, twenty minutes or forty-five. I do not do any of that managed care stuff to generate dollars." Managed care creates an atmosphere conducive to decreased care because "There is an incentive, I believe, by the HMO's, literally to see as many patients as you can." The financial incentive to under-treat is an outgrowth of poor reimbursement fees from managed care.

Therapist A would rather restrict his case load than compromise his attentiveness to patients. For him, a strong therapeutic relationship is necessary to engender trust and enable patients to risk change. He said,

"I know my patients. I know the names of their kids, their pets...They (therapists participating in managed care) do not have the luxury. The patients do not have it; neither do the doctors or the providers...The ambience. The fact that they are not brushed off or hurried out. The fact that...there is a follow-up call to see how they are. Things that just do not happen in a managed care setting."

Therapist A believes the poor reimbursement fees by managed care has led to under-treatment because the reduction in salary creates a new need to try and make a living

Therapist A says, "I made a promise... That I would always work doing what I wanted to do as best I could. And, make a good living at it. So, I will not do managed care."

Therapist A also expressed anger toward the lack of a fee differential based upon one's training or degree. Psychiatrists appear to have been hardest hit by managed care cost-containment strategies. Therapist A was on the board of a managed care panel and recommended fee differentials. He explains, "And I asked, why can't you make even a five dollar difference between psychologists and social workers. The reason that I kept getting was exactly the same; because we do not have to. There were enough people willing to sign up for this rate, why should we. And, they never did. Psychologists, social workers, and psychiatrists using psychotherapy should get paid more for their time and their expertise and be allowed to do that."

Therapist A continued to focus on the therapist's inability to make a living in a managed care environment and how that effects availability to patients. He said,

"Let us assume they get an average of ninety dollars a visit. I think I am high but let's assume ninety. Ninety times seven is six hundred dollars a day. When you take away your overhead, what are we down to, three hundred dollars a day?...I do not think they can make a living. So, now you have to start to scramble. You can get a part-time job...Or else, you have to start compromising."

Therapist A related the themes of money, the business of managed care, and the idea of making a living for the therapist, to the compromised attention and availability of the therapist and the perceived decline in care quality that patients receive.

Themes of avoiding managed care as well as strong disdain for managed care were perhaps the strongest themes evident during this interview. He has withdrawn from the majority of managed care panels and continually tries to avoid working with them. Negative connotations permeated his ideas. The use of the word master above connotes a

feeling that managed care enslaves the practitioner and negatively effects both clients and therapists. His covert dialogue implied resentment toward the justification process of certifying sessions and answering to individuals outside the therapeutic dyad. Some of the negativity involved blows to his ego; a good portion involved concern about declining quality care and premature termination of therapy related to cost-containment strategies.

Therapist A makes all efforts to refer these covered clients to appropriate in-network therapists. He feels the managed care system is "disrespectful to me going into this field, to anyone in this field, disrespectful to human beings. Yes things have to be cost-effective but not this way...I try to avoid them at all costs. I want to provide the service that I provide." This is not possible in a managed care environment. Perhaps unfortunately for patients, managed care has led him to avoid all managed insurance; "I will not take managed care. I basically will not take insurance reimbursement."

Therapist A reflected on issues related to changing the current insurance reimbursement system and therein highlighted one of the positive effects of managed care. He says, "In some ways, being accountable is very useful. I think that there were a lot of abuses in medicine that we brought this in medicine on ourselves. I just do not think this is the answer. There has been, medicine has been ripe with abuses and we did not police ourselves well enough and there needed to be an adjustment. It is just that this adjustment, this managed care adjustment is not useful."

Therapist A focused on creating a payment system with higher co-pays for the patient. He strongly believes managed care created an environment where clients are less psychologically invested in the therapy process because the financial burden is alleviated with low co-payments. Higher co-payments would reinstate client's sense of commitment

to therapy. Therapist A stated, "I do not think time becomes as precious because I do not think each session becomes as precious to them. I do not think they take it as seriously or work as hard if they are not paying money...If you want the help, you have to invest yourself in the help." This change would partially address health care costs; the financial need to restrict care would not exist if clients accepted more of the financial burden.

Therapist A sees the American health care system as being in jeopardy and as collapsing. Individuals entering mental health fields are not as extensively trained because of the subtle changes in focus imposed by managed care insurance; short-term therapies without training in the full spectrum of available treatment options. He believes that health care no longer draws the brightest minds because of the inherent problems with doing one's job and making a living. The system is declining in quality. He said, "I do not think we are practicing medicine as well as we used to, as well as we could."

Therapist B: Textural and Structural Description

Therapist B, in her 40's, is licensed with masters degrees in both social work and counseling. She has been in private practice for 21 years; for the past several years, she is works exclusively as a private therapist. For a short time, Therapist B was the manager of the employee assistance program that was a benefit sold with other managed mental health services to various companies. There she functioned as a certification supervisor and case reviewer. She currently works in a group behavioral practice that has contracts with numerous managed behavioral health care insurance companies. She also works as a therapist one night a week in a practice that shares office space and expenses. Therapist B described herself as having worked on "three sides" of the fence: currently conducting

therapy in a setting that rarely participates with managed care and one that primarily takes managed care insurance, as well as having worked for a managed care insurer.

The interview with this therapist took place at the practice that rarely works with managed care insurance. The physical setting was relatively warm: the therapy room contained a number of couches and lounge chairs, tables, pictures and statues. This interview took place mid-evening in the month of February; specifically, the heat to the building had inadvertently been turned off leaving the temperature quite cold. Therapist B briefly commented on the coldness toward the end of the interview.

A salient theme concerned three issues related to managed care authorization of treatment. The first was treatment length being dictated or determined by the insurance company. She said, "What is different is usually the amount of time I end up seeing somebody for appointments. There is a certain amount of time that each clinician has. People come for maybe five or six sessions instead of extended periods of time because they can't get appointments. Those with managed care spend much less time in therapy."

Therapist B went on to discuss what seemed like arbitrary designations of appointments by managed care companies. She says that duration of treatment, prior to managed care, was and determined jointly by the therapist and the client, that "It was not driven by an insurance company or a managed care company. No one told you how many sessions you could have. You just went until you both thought they did not have to come anymore." This issue came up in the context of ethical concerns. She says,

"I think it is more of a treatment concern for a managed care company to kind of dictate how many sessions people can have in therapy. They say we will give you ten sessions this year or whatever and then rather than have the clinician and the patient decide whether they need more or not, the insurance company decides. So,

I do not think that they take a close look at the treatment plan. I mean, it should be driven by something but sometimes it seems arbitrary.”

She consistently suggested that treatment should be determined by client and therapist; the primary actors in the treatment dyad.

Based on her experience working for a managed behavioral health care company, she believed the arbitrariness of treatment authorization is partially based upon the fact that those making the care decisions are sometimes not experienced or competent to do so. She said, “The paperwork goes to someone who hopefully is a clinician, although it often goes to people who are service people first... There are all of these people sort of looking at it at all these different levels. Making a judgment about it.” She continued with this theme of treatment being determined by individuals with no intimate knowledge of patients and without what she considers appropriate credentials.

Therapist B does believe the justification of treatment has become less stringent for outpatient therapeutic care. She said,

“They are loosening up in terms of less management of outpatient therapists. We have been able to get more sessions without having to fight with them. I think they are finding out it is not financially worth it. They are not losing that much money on five more outpatient sessions, so they are going to use their resources to manage the inpatient where they really do not want people to be there very long.”

This idea is consistent with the literature suggesting the initial focus of managed mental health care is the tremendously high and escalating costs of inpatient mental health care.

Through examples of how she uses diagnostic categories, Therapist B discussed an innovative approach to getting treatment authorized. As a self-described person who dislikes labeling with diagnostic category, Therapist B spoke about “working the system” to get necessary care authorizations. She said, “If you think you will need to work with

them for a long time, you cannot give an adjustment disorder diagnosis that only allows you to work with them for six months. You cannot give a V code diagnosis even. You have to give them something else that will allow you to work with them longer, or be briefer." She makes a diagnosis that benefits the client, in terms of authorization for payment, while keeping the severity label to a minimum. She recognizes the benefits of the DSM-IV for helping structure treatment but dislikes confining a client into categories.

The theme of "working the system" was a focal point for her. She added,

"I usually give the most benign diagnosis I possibly can. Obstacles that we have all learned ways around. You have to go around the system to get what you need. It is not a big conflict for me actually, because I think I feel as though it really is not up to the insurance company to make that decision for me...Sometimes you just have to fight harder for the patient. Phrase things a different way. You know, have to learn to work the system. How to get more sessions for clients."

Therapist B suggests that knowing how to attain more sessions is a beneficial skill in manipulate the managed care system to obtain clinically-indicated authorizations.

The prominence of the theme of 'beating the managed care system at their own game' is evident in the following excerpt: "You have to go around the system to get what you need...I almost never give somebody a personality disorder diagnosis. I do not because things could take a while and that could set us back. I mean, I am still sort of conceptualizing it the same way. It is just whether or not I am writing it down. You present it in a format that a managed care company will accept." In her opinion, "there is no question" that therapists are just writing down what they know managed care companies need to hear to extend treatment authorization.

The above-referenced negative opinion about treatment authorization issues was supplemented by another theme: a dislike for the amount of paperwork that accompany

managed behavioral health care precertification and re-authorization procedures.

Therapist B says, "I mean it is just ridiculous. You know, it is like there is all this paper going back and forth and what does that really say. What does that really do. It is kind of like the government. It [*managed care*] just sort of feels not very positive anymore."

The following excerpt stems from Therapist B's experience working for a managed care company, a position she quit because of its incompatibility with her personal beliefs and values. She said, "I know what it looks like from the other side with all these reams of paper coming in and looking through them. I would waste days just looking through these stupid charts. That is all it was. It was all just paperwork." She highlighted a contention found with other interviewees: there is strong disdain for the amount of time lost to authorizations and the paperwork that accompanies them when this time could be better used for applied clinical work.

Therapist B expressed contempt that individuals without intimate knowledge of the therapeutic relationship or of the relevant, underlying clinical issues were making treatment decisions based diagnostic labels that did not illuminate important clinical concerns. These issues remain the area where managed behavioral health care has had the strongest effect on her practice. She closed this theme with the following, "I do not like that kind of bureaucracy with layers and layers of paper spinning."

The conception of managed care as a 'dollar-driven business' also emerged as a theme for Therapist A. She said, "I really think it is just one great big bureaucracy. People who are reviewing treatment plans do not know anything they are reviewing. I think it is all so driven by money. It is all so driven by cost. I think that definitely effects people's treatment. In the end, you end up paying more than you have to." This sentiment refers to

the medical offset effect: when emotional health suffers, health care expenses escalate through more treatment of physical ailments, lost work productivity. Premature termination of therapy costs more in the long run when individuals need more care.

Therapist B continued her focus on money and elaborated on the arbitrariness of sessions when she added, "Really, so much is driven by how can we get this person out of treatment fast rather than how can we supply the best thing for the person. I understand that; if they are paying for it, there is a limited amount of money to pay for things. So they have to figure out who is going to get what. But, I think it is primarily driven by cost." She believes managed care authorizations are dictated less by clinical criteria or need and more by a desire to contain health care costs and keep profits up.

Therapist B did, however, spend time discussing positive changes resulting from managed care. She did not focus on quality of care or patient investment issues; instead, she believes managed care has allowed more people to enter into psychotherapy because of the reduced cost to the patient, at least during the initial stages of treatment. She says,

"A major difference for the client is that they pay less. Now, I do not know if that makes somebody more motivated or less motivated. You will come more if you have to pay less. Because sometimes people do not have to pay very much out of pocket, I think it has made treatment a little more accessible, at least initial treatment. They might try it. I think people maybe do not wait quite as long to get into treatment....people will come when their problems are not so out of control."

For Therapist A, a lower co-payment under managed care enables more patients to enter psychotherapy and address mental health concerns.

A second positive result of managed care involves the credentials of the therapist. Therapist B spoke of being a part of the credentialing process, both as a professional and as a managed care employee hiring therapists onto panels. She, therefore, added,

"I guess you are sure, if you are going through managed care, that your clinicians have passed all of the credentialing stuff. I mean there are people out there who try to practice without a license. You know that is not going to happen when you go through a managed care company. You know if they have any malpractice suits. You are getting some reassurance about the person you are seeing."

Unfortunately, the hope that managed care could separate charlatans or quacks from qualified clinicians has changed for this therapist who added, "When they first started managing care, I thought well maybe this is a good thing. It will kind of weed out a lot of stuff. But now that I have seen it from the inside, I think it is horrible." Therapist B again routes her discussion to the bureaucratic and profit-making activities of managed care.

Another emerging theme concerned the phases or components of treatment; Therapist B has changed the manner in which she assesses patients and the treatment plans developed for them. She does not believe managed care involvement has caused her to change her conceptualization of patients or the therapeutic approaches she use; instead, there is a change in focus due to the time limited nature of the treatment process.

The techniques she uses remain the same as does her regard for each patient. She said, "No, I do not think that I conceptualize it differently. I think I might just write it down differently." She concedes that the absence of impact from managed care on how she conducts therapy is because, in her current position in a psychotherapy group, an employee was designated to deal with managed care companies. She adds, "I do not think I have felt the worst of all that. I have never gotten in the middle of all that." Regard or respect for each patient remains the same for this therapist. She says, "If I get a patient who is self-pay, another patient who is managed care, the way I work with people is the way I work with people. I do not know if I could even change that very much."

She admits though that she has altered some aspects of doing therapy. She said,

"I think I take a different kind of history. Maybe a little bit with a managed care focus, I will ask much more direct questions about certain kinds of history or they fill out a form. The kind of history I usually take in the first session is a genogram. I often get to a lot of the same questions. But...I probably would ask it a lot less directly. More direct I think (with managed care); more cut and dry on the assessment. In fact, they have to fill out forms but the questions are different."

Regarding the more indirect, genogram approach, Therapist B adds, "To me, it feels sort of unthreatening to people. You know, you get a lot of information and discussion while you are doing that but it is very kind of laid back. I am sorting things out a little bit. I am trying to place everybody and figure out where are you in this family and where are you with all of the people that surround you." She finds that the assessment process under managed care, usually certified for one session, requires much more structure. It can be more threatening to clients but also leaves her with less time to gain a fuller conceptual picture of the client's dynamics and develop a therapeutic relationship.

Therapist B does not believe quality of care decline under managed care and finds no difference in outcome for patients. She believes the time-limited nature of managed care can enhance a patient's willingness to invest in therapy. She says, "Sometimes when it is time-limited, people work harder. Some people just kind of let things drag on for years and years." Though she sees time-limited therapy as a potentially positive change, she admits it effects her focus in therapy, the next theme to emerge. She said,

"I would work in a more solution-oriented, problem-solving way for somebody that I knew was only going to be short-term. What can we do, if we only have ten sessions. What is it that you think we can accomplish here. What is it that you want and how can we get to that. With someone I knew who could be really long-term, I might take my time getting to stuff and work in a maybe, a more analytic kind of way. You do not have time. I think you can work with some depth but I think you do not have time. I mean it takes people time to get to all of the stuff that has been there for a long time. Ten sessions is really not going to do it."

Therapist B will use a short-term approach for patients that warrant it; e.g. marital issues. She has noticed pressure to stay more narrowly-focused because of managed care time-constraints. She added, "You have the luxury of going in a lot of different directions which you might not be able to go in if you knew you had only ten sessions. You might want to go back to stuff in their family of origin, even with a short-term approach. But, you might not be able to get very much out of it if you could only do it a little bit."

The pressure to focus on problem-solving focus is clear in the following. She said, "If you know you are only going to have short-term, you might feel like, let me take time to solve this particular problem...not choose to work with them on things that you know might be more underlying problems. Sometimes I would just deal more with behavior. You do the things you can but, if you do not take a look at what is there, people will not get well." She is not sure if this leads to client recidivism but does believe that, without rectifying underlying problems and developing healthier coping strategies, clients will return to therapy until adaptive problem-solving skills are learned. In spite of these pressures, she continues to approach patients through the eye with which she was trained.

Therapist B concedes that money and finances loom large as a relevant theme. The problem lies in "what is reimbursed. They pay, the managed care companies pay less...I do not even know what the average is. Probably, it used to be about seventy dollars for a social worker; now it is about fifty." Having worked in managed care, she described the strategies managed care companies use to contain costs. She said, "At one point, they were talking about capitating sessions. This is how they really manage care, is they would pay clinicians a hundred dollars for three sessions. If you could treat the patient in one session, then you got a hundred dollars for that hour; if it took you five

sessions to treat that patient, then you were collecting twenty dollars an hour. This is how they were going to manage treatment, get them out of there fast." Capitating care provides a financial incentive to under-treat and provide quicker, less in-depth therapy.

The final theme to emerge for Therapist B concerned ethical issues, for both herself and her clients; foremost of which is confidentiality. Therapist B stated,

"I think there are always some confidentiality issues that the persons have that insurance companies have access to their records. And that is not every patient. I mean it is a lot of them. Some of them sign papers without asking much about it, about why. But mostly, patient are concerned about who is seeing their personal information and where it is going and what it is being used for."

It was while discussing this issue that Therapist B displayed the strongest emotion. She believes that personal, clinical information should remain confidential and private, especially because she finds little merit in the managed care authorization process.

Therapist C: Textural and Structural Description

Therapist C is a male in his fifties who has two terminal degrees: a medical doctor in psychiatry and a doctor of philosophy in psychopharmacology. Therapist C has over ten years of training in psychoanalysis, including personal psychoanalysis and a degree from a psychoanalytic institute. He has two private therapy offices in which he functions as psychotherapist and psychiatrist monitoring medications. Therapist C is also affiliated with two area hospitals, primarily with their inpatient psychiatric units.

Therapist C was interviewed in his office suite in a large office complex building. It is equipped with a small waiting room and doors to the offices of the psychologists and psychiatrists who work there. It is not a group practice in which the professionals share contracts; they are independent practitioners together to save on overhead. The suite

appeared business-like: standard chairs lined the waiting room which was minimally decorated with pictures. A secretary's desk was also in this waiting area. Therapist C's office was large and well-lighted but minimally adorned with personal items. There was a desk against the wall, sparsely filled bookshelves, and a number of chairs for patients.

Treatment authorization issues and the rules and regulations of managed care companies emerged as pertinent themes. Therapist C took issue with insurers dictating treatment length and kind. He said, "They want psychotherapy for maybe six or eight visits and not from a psychiatrist. I would not think of doing it. I am doing kind of what they want but they do not like it when it goes on and on, which it sometimes does. It is the time spent." He has, generally, accepted regulations to limit time spent with clients.

Dealing with managed care reviewers was an area of concern. Therapist C viewed the reviewers as antagonistic, intrusive and unqualified to make care decisions. The beginning of the interview was interrupted by a call from his secretary that a managed care reviewer would only speak to him at a time when the latter had a session scheduled. This call regarded a patient for whom hospitalization was denied, although Therapist C considered him a danger to self. He said, "I want it on record. I was compliant. I will be damned if I am going to chase them down. This is a common occurrence."

Authorization procedures were a continual problem for Therapist C. He added,

"The paperwork is enormous. I can show you some (treatment plans) that are about six pages long; for outpatient. It is the paperwork and the pay when they pay much less. What you do is go through the process. You speak to somebody, file tons of paperwork. Maybe you will get it; maybe you will not. They may allow more than six sessions. Some of them may have made their paperwork less cumbersome; some of them seem to have made them more cumbersome."

Therapist C related that this amount of "unnecessary paperwork" because the therapist and client should determine care, takes away from the time available for clinical work.

The issue of categorizing people was a sub-theme of this topic. Therapist C did acknowledge the positive aspects of using diagnostic categories to guide treatment. In doing so, he alluded to the beneficial changes of EVT or EST for therapy. He said,

"It is nice if you have specific goals. Will spend more time with wife, will get out of bed. You want to make it say that. It puts it on a more schematic setting. It is more apparent so it is less bull-crap. That is one of the contributions of say, the DSM, right. Before the DSM...People had their own criteria. So, it has become more empirical, more quantifiable, more open to investigative approaches to whether things worked. It helps because, really when you are treating somebody, you should have in mind what you are treating. It should not be so nebulous."

Though Therapist C finds categorizing with diagnostic labels helpful, he suggests there is limited benefit to doing so when it comes to treatment planning and clinical progress; quality of care declines when patients are pigeon-holed into the categories required by managed care and care is limited because stringent care categories are not met.

He also linked declining quality of care to the effects on practitioners of low reimbursement rates and the resultant diminished incentive to provide care. The notion of deleterious or negative effects for patients was a salient theme for him as well. In his view, the need for therapy, particularly in a crisis situation, is akin to needing a doctor to remove a kidney stone. The latter procedure would be covered in managed care and, in Therapist C's opinion, so should the former.

There have been other deleterious effects on patient care through managed care's impact on the agent of the therapist. He related this to his hesitation to hospitalize patients in need of that level of care, saying, "Maybe I will try to keep them out of the hospital a day longer. You are saying in the back of your mind, this way I do not have to get a

precertification. I do not have to deal with the reviewer on the phone tomorrow.” This distraction was an added factor in how care was delivered. He said, “It may be that is how you start offering care. You start saying, maybe I can keep the patient out of the hospital a day longer, discharge them sooner. It started out because you wanted to avoid that pre-certification or that phone conversation with that second opinion doctor.”

The direct connection to quality of care is evident in the following excerpt.

Therapist C went on to say, “To the extent that the cost in some amount reflected quality, you have to question the quality. They can say they are just getting rid of the weak from the shaft. I think it [*quality of care*] has suffered for the reasons that I mentioned. They do not get the full spectrum of care that they could get otherwise.” He mentioned the preference for one managed care insurer to use mail order to renew patient medications: “Doctor why don’t you give your patient three months worth of medication. The patient doesn’t come in, gets confused. You don’t want to do that. It’s death by mail.”

Therapist C also saw a decline in a therapist’s accessibility to patients as a result of managed care dynamics. He added,

“I won’t say what I do but it has been known that if you have a certain percentage of managed care patients, then their accessibility to him may be different. You would say, I can give you an appointment in three months, or something like that. Whereas, if somebody does not have it, you would probably say three days. You might want to delay it to not get involved. That is common practice. I think that a doctor may be less accessible to a patient...less accessible to that patient’s needs. They may call them a little bit later, not get them in quickly. It is issues of quality of care, length of care, confidentiality. It impacts the therapeutic relationship.”

The hassles and limitations imposed by managed care lead the therapist to withdraw from contact with these patients so as to avoid further problems and strains.

According to Therapist C, premature termination of mental health care coverage damages client well-being. He noted that, in hospital settings, there is a push to discharge patients early to cut down costs. He said, "Get to the core of the problem? We probably offer varying degrees of symptom relief," in contrast to focusing on insight development; "insight is a more laudable goal that requires much more intense, sustained treatment."

Therapist C's believes symptom focus is a less effective approach than enhancing insight and changing coping skills and behavior patterns. He said, "Yes you are sleeping better. Yes your appetite has improved. Yes you are feeling less hopeless and helpless. So you cannot get anymore treatment. I cannot see the doctor but I still have not reconciled the absence of my father through the years. Managed care does not want to know about that. They want to know from decreased sleep, decreased appetite over the week."

He holds the opinion that patients are adversely effected in the long run. He said,

"This is managed cost. It is not managed care. I think what the outcome is like. Will they be able to function? What will their level of happiness be? The striving for a level of improvement may have to be by the patient alone. If not, they come back and go through another series of certified visits. You may get relief from that particular episode. I am not sure how, over the long-term, that will help you deal with other issues and adversity. I am not sure how that might help you change your coping strategies that ultimately led to this particular incident to begin with. It is a process. It is a long process."

Therapist C gave examples of negative treatment effects resulting from managed care restrictions. One of three extensive examples involved the care denial of a severely depressed man because the man was not overtly suicidal or homicidal. The patient was not functioning on a daily basis, his third wife requested a divorce, he had a stroke and related personality changes, and recently had toes amputated due to neglect of medical problems. Another patient was hospitalized with auditory command hallucinations to

jump out of a window. The insurance company disallowed her hospital stay because documentation suggested some improvement in mood and level of interaction.

Because of care restrictions, Therapist C spoke about the need to document only the negative aspects of a patient's mental status. He said,

"I guess the documentation was not severe enough. You see, that is another thing, what has to appear in the charts is a little bit like congress in session; all the stuff goes on behind closed doors. They look for improvement. The charts always have to appear more severe than they are. You have to carefully chart how you present progress. You have to chart the negatives; you should not chart the positives."

Therapist C repeatedly stressed the need to 'beat the system' by carefully documenting progress in client charts. He also noted inconsistencies between the empirical basis of the DSM and an inability to find an empirical base for managed care's authorization criteria.

Related to this issue of criteria for treatment authorization, Therapist C expressed concern about the credentials of the managed care employees making treatment decisions. Therapist C's negative opinions that care decisions come from individuals other than the therapist are evident in the following. He stated,

"It causes resentment. It causes frustration...that we have to do it. Not always by an erudite, an outsider, but sometimes by someone less knowledgeable than you. I think that the doctors are pretty upset. They are pretty angry. It is demoralizing. It is the second guessing. It is the need to go through a charade. It is the time spent."

These negative opinions of managed care continued throughout this interview, enough that they emerged as a theme for him. Therapist C added, "It is very demonic. See, it is a charade. Organized medicine has become very demoralizing. I mean, it is ridiculous. It is not likely that they will say, look you are feeling down, speak to your new therapist for six sessions so you can prevent twelve later on. Managed care is a racket."

Therapist C likened the current state of affairs to a Russian political issue where politicians and professionals are “agents of the state;” in this case, the insurance industry. He said, You know, all of the politicians that speak against managed care, it was not so long ago that they were pushing for it. People wanted it. But, we have in some measure socialized medicine. There have been certain decisions about what is available and it is not coming from doctors. The doctor knows what the patient needs. It is rationed care. We have destroyed our system. We have Russified our system.” His negative opinions result from two issues: usurping of the professional’s power to make treatment decisions and the lack of an empirical basis on which managed care made those decisions.

Another negative opinion about managed care centered around the fraudulent and abusive practices that Therapist C felt were now initiated by managed care organizations; the fraudulent practices by professionals, which led to managed care, are being continued by managed care companies. The financial abuses have shifted from the professionals and doctors to the upper management of managed care organizations. Therapist C said,

“But now it is like insurance fraud issues gone amuck. That they (managed care) are fraudulent is (laughs). The costs of these managing, are very expensive. I am not sure it saves money. It has created new jobs. They reshuffle the money. Most of the money is going to the executives. These guys are making big, big bucks and it gets lopped of the money that was going to actual health care.”

In his opinion, managed care purports to be the patient’s advocate against fraudulent doctors but really represents the business or profit-making interests of the company. Therapist C views this as a conflict of interest by the managed care company. He notes the cost-saving tactics of managed care: “A lot of times, if you did not get the pre-certification, they say screw you , it is too late. This is the way they save money.”

The next prominent theme to emerge from this interview concerned changes in a number of the components of the assessment and treatment process, particularly the focus of treatment and the therapeutic relationship. Therapist C took strong offense at the limited assessment period authorized by managed care to save money. He saw negative implications for the client's treatment and viewed this as precipitating declining quality of care. He said, "Once you start pushing buttons quicker, once your ascent is quicker or your descent is quicker, then you are losing valuable observation time."

Therapy within managed care has taken away the observation period Therapist C views as crucial to a successful therapy outcome. With a longer assessment period,

"You get to know the patient; see how they do off of medication. Maybe they are not as depressed as they seem. You take somebody that is psychotic, climbing up the wall, talking a mile a minute, what if you sat back and watched them for a few days. Once you medicate them, you do not know what you are dealing with. It is a little bit like calling somebody with an elevated blood sugar level a diabetic. You blunt your ability to really know what is going on if you medicate too quickly."

Therapist C noted a trend to use medications more often to treat patient, as a means of saving money. He said, "And if you do not medicate very quickly, the insurance company gets very unhappy with that. You feel a certain pressure to put them on medication. You know that you are not going to get reimbursed unless you medicate them." Therapist C added that, during his training, the assessment period lasted up to two weeks; for the purpose of getting a clear understanding of the patient's dynamics and the etiology of problems, enabling a clear formulation of a more effective treatment plan.

Medication relation to managed behavioral health care cost-saving tactics is evident in the following quotation: "Different companies say Zoloft instead of Prozac. It may be more cost-effective because the patient has to pay 40% for the Prozac but only

10% for the Zoloft. And the reason is, they will say in the long-term, it is more effective. . . . But, of course the company is saving money. They bought 8,000 pounds of Zoloft.”

Therapist C noted subtle and overt pressures from hospital administration to provide shorter inpatient care. He described “length of stay postings:” charts listing one’s length of stay compared to others in the department and compared to similar disorders. Therapist C felt these pressures contributed to a decline in accessibility to patients. His conceptualization, relationship and approach to clients, and treatment decisions have been effected by the restrictions of managed care; for Therapist C, he has developed a form of tunnel-vision or colored lens through which patient care decisions are made.

Therapist C introduced an interesting notion about a positive effect of managed care: the time-limited nature of managed therapy helps rid the system of malingering patients by providing an excuse to set therapeutic limits and perhaps motivating patients. For Therapist C, the most positive outgrowth of managed health care concerned fields other than mental health; specifically, the fact the managed care-instituted preventive measures and annual testing. He said, “It might increase inoculations and increase awareness and testing. I think that general health, not necessarily in mental health, has not it led to the introduction of prophylactic measures of health care.” Unfortunately, he believes the positive changes from managed care have not occurred in mental health.

Money and finances were also a thematic issue for Therapist C; specifically, the impact of the fees reimbursed in managed care and its impact on him making a living. Earlier, Therapist C’s spoke about forfeiting reimbursement from managed care for treatment was denied when he did not file paperwork in time. He added the following:

“You know, even when they review, there is no guarantee you will get paid. And a lot of times it happens you do not. I have been in situations where they have called me to see a patient in a crisis situation and they refused to pay because they did not have them in the computer. It is the paperwork and the pay when they pay much less. It is so much more labor intensive.

Therapist C related this to the time he loses for performing clinical duties. He continued to discuss the lack of financial incentive to work with managed care because of the cuts his income has taken. He added, “The bottom line is going to be money. The rates are being cut. And, you know, the patient is paying ten bucks, and what if they do not show up? Can I bill them? You can’t bill them if they do not show. So, there is no incentive.”

A final theme for Therapist C concerned ethics; specifically a conflict of allegiance between patients and managed care companies. He said,

“You have been trained as the ombudsman of the patient. What has happened now is very insidious because now both the doctor and the patient are at the service of the insurance company who could not give a squat. There is a change in the dynamics. There is a third party involved here now. Patients... think they are getting something for their money; sometimes they are, sometimes they are not. The issue is, the doctor knows what the patient needs. Now, you cannot do that.”

In the past, patient care was his primary concern; now cost is a factor in the triangulated therapeutic relationship and creates “an absolute conflict of interest.”

Another ethical concern was confidentiality. Therapist C says,

“What about showing a patient’s record. What about issues of privacy. Confidentiality, where did that go. That is a joke. You may write a note and think it is sacrosanct but it is not. The insurance company not infrequently asks for, they want to review your notes to see if it conforms to the diagnostic code, to the treatment code. You have to send them your progress note.”

Therapist C took issue with the intrusiveness into the treatment process by insurance companies that are not qualified to use the clinical information to make care decisions.

Proposed recommendations toward amending the insurance system as it now exists formed a minor theme for Therapist C; especially the formation of independent review organizations. First, he and a number of colleagues are developing a national external review organization. In Therapist C's experience, external reviews as they currently exist function for the managed care company. He said that some states require independent reviewers that are not beholden to the company because those financed by managed care might feel pressure to make decisions in their favor. He added, "The money ultimately comes from the insurance company. But the external review is a plus."

Therapist C felt the pendulum of change needed to swing "towards a system that was more commensurate with what we had with traditional health plans. Less overseeing." Because of the numerous problems that he felt grew out of managed care rules and regulations, "I would want to get rid of pre-certifications, doctor to doctor reviews. These cost money. I do not think they are effective." The procedures are costly for the professional in terms of time lost that could be better spent on direct clinical care. In addition, Therapist C would alter the laws concerning suing managed care by making managed care companies culpable for treatment decisions. He said, "I would like to see them be able to sue. Why should they be exempt. I mean, they have taken advantage of so many things. They are not culpable for much of anything."

Therapist D: Textural and Structural Description

Therapist D is in his forties, conducting therapy solely in a private practice. He has a doctor of philosophy degree in psychology, licensed since the mid-1980's. For the first five years post-doctorate, Therapist D conducted therapy at an inpatient psychiatric

hospital. Therapist D has published work on various aspects of psychotherapy with different populations. For reasons to be disclosed later in this narrative, Therapist D has recently resumed professional training at a psychoanalytic institute.

Therapist D shares an office suite with other psychologists. The waiting room into the suite is unusually small without many adornments. A secretary or office manager is in view through sliding glass doors. Therapist D's office is a bit more comfortable and intimate; there was one large couch for patients which Therapist D faced in a desk a short distance away. The room was small but uncluttered; it suggested an air of warmth but a tempo of working without distraction. Numerous books housed shelves around the room.

The overarching theme to emerge from the interview with Therapist D was his concerns about ethical and legal violations; specifically, confidentiality, informed consent, and privacy. His reflections returned to these issues repeatedly. His disdain toward these issues took precedence over any reductions in income that accompanied working with managed care. He said, "One thing about the fee cuts, if they did not cut in on my privacy, I would not like it but, I would just work an extra couple of hours. It is not necessarily the work burden but the work burden and the coercion to violate privacy."

Therapist D opened the interview with the following, "The intrusion on privacy was tremendous. You went from basically just having to provide dates of service, CPT codes, cost, diagnosis. All of a sudden, you had to provide all kinds of clinical. There was an expectation of providing that. The other is the interruption of service, constantly being told that treatment would have to stop unless information was provided." In the past, he continued, "Every once and awhile, they would ask for a prognosis. But, other than that, they did not really intrude on the content of it."

Therapist D was very disturbed by the threats to withdraw treatment approval unless clinical information was provided which persisted in spite of his willingness to provide managed care companies with copies of the New Jersey Peer Review Law. This law is specific to the state of New Jersey and restricts the process for disclosure of clinical information about clients, even with their consent. The law stipulates that only basic diagnostic and prognostic information is released. If a third party does not accept the therapist's decisions, the former must contact the New Jersey board of psychologists who appoint two reviewers to make the care decisions; this board forwards the decisions only to the insurer without disclosing detailed clinical information.

Therapist D was quite angered by how managed care handled knowledge about the New Jersey Peer Review Law and the effect of disclosures on patient care. He said,

“So the fact that I would advise the insurance company and they would insist anyway, frankly pisses me off. It puts the whole situation in conflict. Now, we have a patient who has a benefit. They cannot use the benefit unless they disclose information. They are asking me to essentially violate the law. And their response is, we'll send them to someone else if you don't provide the information.”

Most managed care insurers claim to be unaware of the law and ignore his complaints.

Therapist D regarded the requests made in the past for basic treatment information as reasonable; the demand for specific clinical details, beginning less than 10 years ago, was an invasion for the client, a breach of confidentiality for himself, and a distortion of treatment for patient and therapist. Beyond basic demographic and diagnostic data,

“They did not know anything more about the patient than that from me and they did not really intrude on the content of it. Now they are asking for history of drug and alcohol abuse, history of sexual abuse. What are the problems you're working on. History of the problems. History of treatment. Tremendous intrusion on privacy of patients. Before I used to have the file locked up in my office and I had total control of the information. Now, information is given and punched into a

computer system somewhere. And, I have no clue what they do with it. I could not for a second provide them [*patients*] with any assurances of confidentiality.”

Therapist D believes there are distortions and disruptions in treatment resulting from the intrusion on privacy; time spent discussing managed care during therapy sessions, patients having distorted expectations about the healing process, and denials for necessary coverage. Therapist D added, “It totally distorted how I did treatment. I am interested in doing psychoanalytic/psychodynamic work. I do not like to focus every three sessions depending on what the insurance company wants to do.” Treatment distortions were not intentional “but it was a constant presence. You are always dealing with is there time to file the paperwork. What should we write. You know, it became a focus and it became a tremendous disruption.”

Effects for clients abounded from these intrusions. Therapist D saw a change in client expectations that treatment should progress to successful termination quickly. He said,

“Now, we have a third party constantly giving the message that treatment was going on too long. It put this negative dynamic into the treatment where an expectation was built up that in six sessions even the most complex problems should have been solved. I had a guy who had been recently discharged from the hospital with full-blown OCD, severe alcohol problem, We were approved for six sessions. It would take five years to treat a guy like that successfully.”

Managed care’s expectation for shorter treatment in effect creates the same expectation in clients who now expect quicker, more immediate gratification from therapy.

Therapist D believes that managed care has created a consumer model in which more individuals sample treatment initially but less are returning to therapy because “It was probably a less satisfying experience. It is so artificial. It is not an ending that occurs because some issue has been worked through. It is based on an external and arbitrary

time-limit, not some sort of subjective outcome either on the patient's part or mine."

Though Therapist D believes no client can consciously work faster to push time-limited therapy to a successful ending, he believes managed care restrictions on length of care have adversely effected the dynamics of the treatment process for the patient.

Short-term versus long-term models emerged as a theme related to the quality or success of therapy; another long-term effect on patients. He has strong convictions about what kind of therapy resulted in lasting changes for clients but acknowledged that short-term and crisis-oriented therapies held rightful places in practice. He said,

"I tell them, if you are interested in quick solutions and quick answers, I can probably help you find someone else but I am interested in understanding some of the deeper causes so that, not only you get through this situation, but possibly you can prevent getting into other problems. If the insurance company withdraws support, we'll work together to come up with a mutually agreeable fee."

The development of insight is necessary for lasting change; by understanding problems and making necessary behavior changes, healthier coping strategies can be developed.

Therapist D addressed the problem of the managed care setting arbitrary limits on treatment length and the their misuse of short-term therapies. He said,

"People have been studying short-term therapies since the 1900's. The short-term therapies were still six to twelve months not ten sessions or less. In times of war when there were damaged people coming back, they tried to maximize the amount of treatment. They were very selective about who was appropriate for this kind of work. It was not an arbitrary number of sessions. They did careful studies. With managed care, they want ten sessions for everyone, even the psychotic drug abuser who has had twenty different treatment stints. It cannot happen."

Therapist D expressed contempt for the inappropriate misuse of short-term therapies and, by implication, disregard for the need for longer-term care.

The following quotation was a cogent analogy for what Therapist D perceives as managed care's effect on care quality or treatment effectiveness. He said,

"It would be like saying, if you are supposed to take an antibiotic for fifteen days, and instead the insurance company only pays for ten days of antibiotics, then you have a lot of people who are going to be stopping it prematurely. I don't think the quality of the antibiotic is compromised but the effectiveness of it is going to be diminished... You adhere to the model of treatment that you think is appropriate and effective and you try to work within the system as long as you can. So I do not think, I hope people have not altered the way they work in response to this."

This analogy is a poignant one because it makes a strong argument for the need for therapy which may go longer than that which managed care wants; for those clients, shorter-term therapy would render the process less effective than it otherwise might be.

A final effect of managed care effect on the effectiveness of therapy relates issues of the intrusion on privacy and confidentiality to the therapeutic relationship. The issue concerns a patient's willingness to disclose personal information to the therapist in today's insurance environment. Therapist D stated, "I certainly do not trust what they do with the information. If I were to go into treatment now, and I knew the information that was going to be reported, I would be much more guarded than I would naturally be anyway. Is this going to go on a form? In a computer somewhere?" The threats to patient privacy can enhance the natural guardedness that patients bring to the therapy process.

Therapist D gave an ironic example from an article he had read in which a managed care employee was giving an in-house presentation. He selected a computer file for an example, supposed to be a dummy, and his personal therapy file came up. The gentleman sued his own company with a substantial payment resulting. He stated, "He successfully sued for breach of his privacy. Who couldn't punch into the system?"

In discussing the effects on clients, a more insidious issue concerned patient resistance and investment in therapy. According to Therapist D, "There was always resistance to treatment. It takes time. It is relatively painful if you are going to get into the

things you need to get into. It costs money." Therapist D added, "But now, you have an entire industry telling people they have been getting way more treatment than they need; that treatment should not go on more than five, ten sessions. There should be short-term, direct interventions. It just sort of fueled the natural resistance. It facilitated a lot of resistance to getting deeper into treatment."

A related theme concerned patients financial investment in their treatment. For Therapist D, patients become more invested in treatment when there is more of a burden to them financially. Therapist D believes that the ability to sample treatment with little cost resulted in patients more looking "for instant gratification than it was for a good fit to hunker down and do some real work." He added, "It is more satisfying to have someone who thinks they have problems they want to get some serious help for than to have people come in and be sort of casual and cavalier about it; who want you to give answers to complex questions in an interview." Without financial responsibility "there is not the serious investment in the treatment. Managed care totally takes it out of their hands. They come in and flip you ten bucks and then they leave. When they know the money that it being spent on the treatment, I think it is a much healthier dynamic."

Therapist D believes that higher co-payments help increase patient investment in clinical care and would change the negative dynamic this situation has created. He said, "I don't think it's the money per se. If they are only going to pay 10 or 15 dollars but bear the responsibility, I am okay with that. I am more interested in their sharing the work and taking their share of responsibility than I am the absolute amount of money. But as a totally independent factor, if you are only paying 10 bucks versus 50, I think it does effect their valuation of the service" By responsibility, Therapist D referred to insurance

paperwork and decisions about release of clinical information. Financial responsibility has traditionally been the avenue in which investment manifests itself.

An emerging theme, related to the above, concerns what Therapist D labeled devaluing the treatment; the importance of the therapy relationship and the amount of clinical time, and the associated therapy approaches, needed to successfully help patients. He felt managed care devalued treatment first by assuming that patients could easily be sent to other therapists for care. He said, "You are interchangeable; just another one of the providers in the system. There is no thought about transference, management of transference, and the importance of the therapy relationship as a therapeutic tool." He suggested that many patients do not disclose deep, personal information until they feel trust: "There are things I do not find out about certain patients for a year, two years, three years. It is because they do not feel safe up until then. It attempts to force people to come out with everything before they have any relationship. It is a ridiculous system."

This mentality also helped Therapist D avoid counter-transference reactions toward patients that stemmed from his resentment about treatment intrusions and delays. He added, "In order to keep myself from getting totally resentful about it, I would make it part of the treatment; make it a shared problem." To handle the conflict of interest, he brought issues regarding managed care authorizations into each client's therapy, saying,

"here is what the insurance company is asking for, how do you want to respond. understanding that, if you make it look like there is no problem, chances are they will not support treatment. I would rather do that then the patient be completely oblivious to what is going on. It is information that is being released about you. You need to take responsibility for it. I think, for the patient to make a fully informed consent, they should have total control of the information."

For Therapist D, this approach helped to counter the resistance generated by managed care involvement and was in line with his approach to treatment: empowering clients.

A closely related theme is the legal counterpart of these ethical concerns.

Therapist D was less concerned with issues related to ERISA, willing to accept his share of responsibility for patient well-being and the safe termination of the therapy. The legal concern relates to patient's future reactions to personal information that could be identified. He added, "It is going to be on their record in some computer system and I do not know who has it. In ten years, when it turns up on a credit report saying major depression, then they go ape and want to sue me or something." Therapist D was more concerned with violating the Peer Review Law. He said, "Managed care companies do not give a shit about my license and I clearly do. It is my livelihood. I resent that they routinely and without regard, demand that you violate the law. I will not do it."

Another salient theme to emerge reflected concerns about administrative time lost to dealing with managed care paperwork and regulations. He said,

"Administrative time went through the roof. I am on the phone half the day trying to get paid for five months ago. It is invading my clinical time. It was an absolute nightmare. If I have to spend time on the phone fine. But there is no personal responsibility on the other end. You talk to Joe on Monday; nothing happens. I call back; I get Steve. Steve is supposed to take care of something. Two weeks later, it does not happen. You could go out of your mind. You are still not paid. It really was just so unsatisfying and frustrating. I could not tell you."

This time could be better spent on additional clinical care. It was not the time per se that bothered this therapist but the fact that it was used for illegal and irrelevant activities

The next, related, theme to emerge involved issues related to finances and income due to managed care reimbursement fees. He said, "Horrible rates of reimbursement. Taking 40,50% pay cuts without being able to negotiate that at all." He added, "You

know, when you take a 50% pay cut and in four years you do not get a nickels raise, it is that kind of ridiculousness. I would say most of them are maybe thirty to forty percent.”

Therapist D was very angry and contemptuous about being encouraged to join managed care panels by APA and NJPA. He reflected on being told about this formidable, as-yet unknown insurance system. He was advised to join as many managed behavioral health care panels as possible to avoid being locked out and having his practice fold. He said, “I thought if we acted as a unified body, if APA and NJPA told everybody sign up for none and we will act as a unified front, I thought we would have been much better off.” Therapist D felt APA and NJPA members should have been directed to unite in protest to avert the negative ramifications that have abounded.

Therapist D aborted involvement with managed care; the next theme to emerge from this interview. His avoidance involved using out-of-network benefits and negotiating the remaining fee with patients, rather than manipulating managed care plans to get care approval. He stated, “Most of them stunk. And, within a years or two, I started dropping out of them, figuring I would rather not do the work. You know, you are still accepting all of the responsibility for care; all of the liability...I said screw it. I would rather have no patients than deal with that. I mean, I had just had it.” From Therapist D’s account, many patients were similarly frustrated, agreeing to use out-of-network benefits rather than deal with managed care restrictions. He said, “I took a significant pay-cut, even from the managed care fee but I was doing the kind of work I wanted and I am fifty times better for it. I want to deal with patients. You cannot work that way.”

For this therapist, the intrusiveness on the therapist-patient relationship and the disruption to treatment from dealing with managed care administrative issues were

deciding factors toward his decision to abandon working with managed care. He added, "If I do not deal with managed care, all we talk about is what the patient brings up and what is on their mind; the way it should be." The decision to become an out-of-network provider avoids the disruption in treatment and allows more time for clinical work.

The next theme to emerge, related to aborting involvement with managed care, related to positive changes perceived as emerging from managed care. Therapist D's convictions about managed care and his concerns about pressure to abandon longer-term work, were strong enough to push him into further training at a psychoanalytic institute. He stated, "It really crystallized my desire to become an analyst. I was not formally committed to formal psychoanalytic training until I got fed up with managed care."

The following quotation clearly describes his thoughts,

"I was starting to feel like I was out on a limb without any support because NJPA and APA, early on, were supportive of the short-term therapies and abandoning long-term work under the financial pressures. You feel like you are committing malpractice if you have a patient for a year. Analysts understand the value of the long-term work and the need to go longer to get deeper... where the interest was on patients and patient care. They were not bred on third party reimbursements and so there is not the attitude of the necessity of third party reimbursements... It is purer clinical work, like before managed care. Yeah, it affected me that way."

Rather than change what he saw as appropriate techniques and approaches for patients, he left managed care and affiliated with analytic training to solidify these beliefs.

Now, Therapist D has found that both he and his patients find their work together more satisfying and productive, mostly because they follow their own treatment plans. Without the pressure imposed by managed care, "I felt a 100% better. It was a significant period of time, maybe six, nine months, where I took a significant pay-cut because I was

getting tons of referrals that I lost suddenly. But I felt much better. The patients I was working with felt better about the work. I personally feel much better not having this.”

A persistent theme emerged regarding changes that would be necessary to make managed care systems more acceptable and successful. Therapist D spent considerable time discussing an insurance system akin to a compromise between managed and fee-for-service care. There would be lower annual allotments for each individual but eliminate the need for certifications or authorizations and “I would take a pay-cut. But let me still determine the treatment of the patient and stay out of it other than that.” He concluded,

“Without having to disclose information, without having to make these arbitrary treatment decisions, you have got three thousand a year or mental health, for outpatient psychotherapy and you and the doctor work it out. It puts it back on our lap. I think the fear is, if you had ten thousand allotted, every patient would use up ten thousand dollars worth and they would go broke. You read Freud’s work in the 1890’s and there were people who were dropping out after two sessions. It is an inherently painful process. It is not like people flock to it like they are going to the movies. There are still only a minority of patients who are going to stick around to do the long-term work anyway.”

This hypothesized system renders intrusiveness a non-issue and preserves the therapeutic relationship; treatment care decisions remain between therapist and client. Therapist D added “We decide how much treatment...not some third party. If they are going to subsidize it for some portion of that fine. But send in the money and leave us alone.” This system has a built in cap on monetary allowances and naturally creating a check and balance system on abuses. It considers the costs involved with maintaining managed care organizations and how these sums of money contribute to health care costs. He added, “There are studies that are done that the infrastructure to support managed care companies is so expensive that it is like a wash: the money they are saving by disrupting treatment is almost offset by all the people they are hiring to manage it.”

Therapist E: Textural and Structural Description

Therapist E is a accredited clinical social worker with a registered nursing degree. She has been in private practice for over fifteen years; prior to this, she worked in an inpatient clinical setting in a psychiatric hospital, conducting therapy with various patient groups. Therapist E is in her fifties. She has ten years combined psychoanalytic training and personal treatment, though she describes herself as an eclectic therapist.

Therapist E is in a multi-person group practice located in a large house in an upper scale neighborhood and lacks the appearance of being offices. In spite of the setting in which she works, the waiting area of this practice was quite small. It included chairs, a couch, books and magazines but primarily had a number of children's toys. Therapist E has a large number of children and adolescents as client. Therapist E's office was quite large and reflective of her personality; warm, comfortable, and engaging.

The over-arching theme for this therapist was the techniques she developed to navigate the system of managed care to continue treatment with clients "because the whole spirit of the thing, I did not agree with. So, I found ways around it." Having worked in a hospital setting for a number of years, Therapist E had extensive training in writing treatment plans. Manipulating managed care paperwork and authorization forms was an area Therapist E easily navigated. She candidly stated, "I managed the paperwork and I managed the treatment plans to reflect what I knew the patient needed in terms of sessions. I have no compunction about it at all. It does not feel ethically wrong to me. I always aligned with the patient. We were going to get whatever we could"

Therapist E's management of initial authorization forms and treatment plans was calculated to help ensure approval of further care for clients. She said,

"I never got treatment plans back because I knew what they needed to hear. I knew the difference between goals and objectives. I knew what kind of treatment to list. My first treatment plan was replete with detail and, since I worked in a hospital, I was able to medicalize the treatment plans. If you sent them a good one in the beginning, they didn't really pay too much attention to the follow-up ones."

Therapist E was very open with clients about her tactics to gain care approval:

"Sometimes I would say to the patient, we have got to get some more sessions here. I have to make it as bad as we can make it so that we have a way to go. You kind of knew after a while where you could not take it. Even though the patient was functioning better, you might not have them functioning that well, just to enable them to stay in treatment if you felt they needed it."

Therapist E recognized the necessity of charting progress carefully and in a way that ensured continued and clinically-indicated care approvals.

She intentionally made her treatment plans and authorization forms very explicit, behavioral, and overt yet minimally personally revealing. With anxious or depressed patients, "I might list cognitive management of affect and I would document using a behavioral treatment to deal with feelings. My initial plan was to establish relationship, support efforts to try out new behavior patterns. If there were obsessive thoughts, list the techniques of flooding, thought stopping, be fairly specific in those treatments." She believed managed care was less concerned about her lack of personal detail and more concerned about documentation that was congruent with their guidelines. It was interesting to hear that Therapist E was trained in psychoanalysis and her primary approach was long-term, relational therapy. She added, "I try to use some of those [*short-term*] techniques within the context of a more psychoanalytic understanding of the case."

The second significant theme to emerge concerned ethical issues of informed consent, confidentiality, and privacy. Confronted with these issues, Therapist E used the techniques for manipulating managed care to deal with them. For example, she would mail, not fax, treatment plans to avoid them being seen by unauthorized persons. The following quotation is revealing of her stance toward patient confidentiality and privacy:

“The other thing is the whole notion of patient confidentiality. Basically, my whole approach has always been, to insurance companies, to tell the absolute minimum of what they need to know. In terms of history, I would make it very general. I would try not to list specific, personal details. I withheld a lot of personal information and speak in very general, symptomatic terms. Basically, I never said what the real problem was; I never went into what the real issue was.”

In what follows, Therapist E's manner of obtaining care approval while maintaining client privacy is also evident. Therein, her opinions about using diagnostic labels and categorizing clients is also evident. She said, “I felt like I could get around the confidentiality thing. I do not have a lot of diagnoses that I sent to insurance companies. I tend to diagnose adjustment disorder with mixed emotional features one heck of a lot. I didn't really give insurance companies diagnoses that were hugely accurate and as far as I am concerned, that is not the insurance company's business..” The connection to navigating managed care rules and regulations is apparent. Therapist E's behaviors reflect the belief that client personal information was privileged.

Being involved with managed care was an ethically conflicting for Therapist E; it was financially necessary for her but a decision with which she was never comfortable. Because of the cognitive dissonance it caused her, she employed a number of what she terms “manipulative” techniques to deal with this. She said, “The way I managed it or rationalize it was to say that I was, obviously, going to tell the patients about these

documents, let them read what I had, tell them what I had to inform the insurance company and personally be the guardian of information that I felt was damaging. I would censor it and I would only give the bare minimum that I needed to get sessions."

Therapist E used other innovative techniques to guard the privacy of patient information which, she admits, are passive-aggressive but done with the intent of maintaining confidentiality for herself and her patients. She would at times forget to fill in medication names and dosages, only writing anti-depressant. She said, "I do not think anybody reads these stupid things anyway. Also, the other thing I did, which was sort of passive-aggressive, my hand-writing is horrible and I did not make any effort to improve it. I would, especially if I had to provide any history, I would not make that very legible."

Therapist E would "act-out" by leaving numerous pieces of educational literature in her waiting room regarding patient protection of information and agencies to contact with concerns or questions. She said,

"I felt like I was going to be in this but not of it. I would do the managed care thing but I would guard my patient's rights. Initially, I did not want to ruffle feathers because I needed referrals. I did not want to be too openly resistant. I always felt like I was the patient's advocate. I would not do anything to compromise the patient's well-being in terms of information given to managed care while still working in the system."

For example, because Therapist E puts strong weight into doing a thorough and extensive evaluation over a two session period and because insurance companies would not pay for a lengthy evaluation, Therapist E "would simply bill it as two different days. Nobody pays for a double sessions." Therapist E often used this adaptive technique to counter managed care's deceptive tendencies with authorizing sessions that, when not used within a certain time period, were lost unbeknown to her. She added, "If I had gone

over, I would just wait a couple of weeks and bill it. I never took extra sessions. I never got paid for something I did not do. I worked it around so most of the time I got paid."

Another emerging theme was the effect managed care had on Therapist E as a person; anxiety and distraction with obtaining care approvals. She said, "It raised my anxiety level in terms of doing clinical work because I was always wondering how many sessions I would be able to get for a patient. What kind of diagnosis was I going to use; which is going to get me the maximum number of sessions for someone who needed them." She added, "I always felt it was hanging over my head. That was aggravating"

Therapist E viewed the regulations and paperwork associated with managed care primarily a bookkeeping issue but the anxiety and distraction to her are evident. She found it difficult to keep track of it all and added, "I had to figure out who needs to have their treatment plans sent in when and keep track of if they are paying the right amount. That was onerous to me because I would find myself not getting treatment plans in and then being in a session, I would look down on the little checklist I had and I would think, here I am into this session, now I have to get them to back-date it."

The nature and importance of the therapeutic relationship emerged as a theme for this therapist as well. She initiated this topic when discussing the evolution of her therapeutic techniques from more passive, analytic ones to more active relational and eclectic techniques. In her view, the relationship was the vehicle to empower patients and maintain that change. She moved away from a strict analytic approach because

"I don't think analytic work works. It works because of the nature of the relationship and a therapist's ability to help someone empower themselves. I don't think you help somebody empower themselves by sitting quietly and doing nothing. Many people we see are very compromised inter-relationally, with not

many internal resources. They can't connect to you. You have to make a bridge, you have to build a positive transference before you get into their negative stuff."

The therapist's ability to connect to clients is the vehicle from which clients begin to self-disclose, trust, and change. She said,

"If you have a good therapist who is related and intuitive and has a positive regard for people and a good sense of their own boundaries, they can learn lots of techniques that can be very helpful to people. I do not believe, if you take a person of the therapist who does not have those qualities, no matter how many techniques you teach them, that you cannot have a good therapeutic outcome."

The person of the therapist supersedes volumes of techniques one might acquire to become a proficient psychotherapist.

Therapist E offered lengthy thoughts about individuals working on managed care panels. She alluded to this issue above when discussing the importance of the therapy relationship for therapeutic outcome. The emerging theme was a conjoined one: a belief that the quality of care, offered under managed care, has declined due to the ability level of those individuals working for managed care panels and managed care employees.

Therapist E first addressed those individuals who work for the managed care company itself: care reviewers, intake clinicians etc. She said, "I have had experiences talking to the care managers that were insulting in terms of the suggestions made to decrease treatment. People making these clinical decisions that did not know what they were doing. Yes I think that people are getting compromised care because care is cut off before it is appropriate." Therapist E sees a trend toward higher use of medications in lieu of psychotherapy because of the cost-savings of the former.

The following thoughts reflect her beliefs that more competent therapists and mental health professionals have opted to leave managed care and avoid dealing with

those systems. She said, "The best and experienced clinicians are not available within managed care networks. People who are in those networks are not getting the best clinical service because professionals who are good and experienced are not willing to work for 57 dollars an hour and be told what to do by someone they have far more experience than." She added, "I think competent people pull out because they don't want to be told what to do and don't want to work for no money. I think primarily because it [*treatment decisions*] is not clinically indicated."

By extension, Therapist E believes that those professionals who opt to remain on managed care panels offer less quality service: "Why do I think people get in and stay in? They are inexperienced and want to build a practice, get referrals and get themselves known. I think people who cannot make a living stay in too. That to me is indicative of people who are not so hot." She reflected on psychiatrists who compensate for decreased income by cutting session time with patients. She said, "Some of these psychiatrists stay in because they can pack a whole bunch of med evals into an hour. I know they do not see these patients for fifteen or twenty minutes." Thorough assessments are lacking in the practices of these psychiatrists who she feels place patients on medications without thoroughly understanding their histories.

The assessment process was an important issue for Therapist E; a thorough and accurate assessment is a precursor for successful therapy. She conducts extensive initial evaluations that often involved testing, gathering lengthy developmental, personal and family histories; particularly for the many adolescents she sees in her practice. She said, "I always see someone for a double session. It really helps people to come initially for a

double session because it gives them a chance to know you. You can really sort of figure out what you need to do. I instead of doing this ad-hoc stuff.”

Therapist E would like to see insurance reimbursement extended to pay for more thorough assessments because “You do not have time to gather all of the history you need to gather. I do not think you can know what to do unless you know the context into which it fits and know what is wrong. People rush into treatment before they really understand the etiology of it. Etiology is more than just do you have trouble sleeping. It is a whole other thing.” For Therapist E, there is a pressing need to clearly rule out other potential diagnoses and fully understand family background and dynamics before beginning a treatment plan, particularly with children and adolescents,

Therapist E saw three positive outcomes since managed care's existence: a greater number of people sampling treatment, the push in the mental health fields to develop more specific and efficient treatments, and the accountability on abuses in the system; however, this last change was also viewed as a bane of the system. Therapist E believes that the lower out-of-pocket cost for therapy under managed care has allowed more individuals to enter psychotherapy initially. She said, “Maybe there are more people getting treatment today. I think in some ways it may have educated people more about treatment because it seemed more available initially. I think that is true.”

Regarding accountability, she said, “I think there has been a little more overseeing of things. Now if it is effective or not I do not know. I think it has really pushed clinicians to take a look at what they do in each session and try to be a little more efficient in helping people; a little more thoughtfully. I think it has shifted therapy to a more focused treatment. I think that has been good, a very good thing.”

Therapist E sees positive effects for therapists-in-training. She said, "I think there has been an impetus to try and get more specific training for clinicians at techniques; to be more specialized in terms of tailoring treatment to patient diagnosis than before. The catch-22 to this issue is that "It has gone too far with managed care. These are the guidelines and everybody has to fit into that template. There is no allowance for Axis II disorders and that gets in the way of most everybody from doing things they are supposed to do. There is not much appreciation of that. The pendulum has swung too far."

The decision to avoid the managed care system also emerged as a relevant theme for Therapist E who stayed with managed care as long as she did because of financial difficulties in her personal life; she experienced conflict when she remained joined to managed care because she did not ethically support the concepts therein. Monetary reimbursement played a large role in her decision to abandon working with managed care insurance. She said, "I got aggravated with the whole thing. I just got tired of being paid miserably. All that sticks in my brain now is that is 57 dollars. I was getting plenty of referrals but it was costing me money to be in managed care. Two years ago, it was with great trepidation that I got out of managed care. But, I have done fine."

Despite family financial constraints, Therapist E still chose to exit this insurance system. Since being out of the managed care system, she is happier in her work and has significantly more time that was used to deal with managed care paperwork and rules. She also finds that "it has allowed me more time to do reading, to do more specific training in terms of clinical reading, periodical reading, in terms of doing treatment."

Like many of the interviewed therapists, Therapist E and her patients often opt to use out-of-network benefits rather than deal with issues that are troublesome to both

parties. She added, "I have patients that I see at very reduced fees but that is my choice." Her clients became aggravated with managed care plans as well. She adds, "I hear it all of the time, well I did my in-network person and they were terrible and the psychiatrist did not speak English and I really did not get helped." Her patients would rather pay more out of their own pockets and receive a level of care with which they are satisfied.

The final theme to emerge concerned her extensive thoughts about changing the current managed care system to make it more productive and satisfying for all parties involved: a product between the current, stringent managed care format and indemnity insurance plans. She also reflected on co-payments and the level of client's investment in the therapy process. She said, "I do not know that this is workable but, it seems to me that people probably ought to be paying a little more than ten dollars a session. They ought to be paying something meaningful so they come in and use the work. If people are paying for something, they are invested in it. That is why you do not see anybody for free because there is something about taking responsibility for your part of the relationship and bringing something to the table and valuing the interaction, valuing the treatment."

Because of concern that the uninsured are unable to receive care unless they pay full fees, Therapist E added,

"If there were some product where they reimbursed the clinicians a little bit more and patients or corporations picked up a little bit more. If there were such a thing as a managed care company that paid say fifty-fifty... The patient would be paying more, the clinician would be getting more and it would be more meaningful than ten dollars a session... you could have twenty-five sessions a year."

Therapist E closed the interview by connecting these thoughts about changing the insurance system to the issue of mental health parity. She believes that most mental health disorders and chemical brain reactions but does not equate chemical changes with

labeling mental health issues biologically-based. She said, "Your brain is part of your body. It is not some separate thing. We are talking about depressions, anxiety disorders, eating disorders, OCD as having a chemical basis. We are made up of brains that direct our emotions, our feelings, the hippocampus, everything." Though couched in medical terminology, Therapist E alludes to the fact that, though parity for mental health issues and disorders exists on the books, it is not fully recognized by insurance carriers.

Therapist F: Textural and Structural Description

Therapist F is an advanced practice nurse with a number of training degrees: a masters of science in nursing, a certified nurse practitioner, an advanced, certified clinical specialist, and a bachelors of science in psychology. She has been practicing psychotherapy since 1986 and currently works out of a house. Her therapy area therefore has all of the amenities of a home, from furnishings and decor to adornments and pets which appeared to create a very relaxed and inviting atmosphere.

One of the first themes to emerge during this interview concerned a decline in quality of care borne from the rules and regulations of managed care insurers. Therapist F felt a push from managed care to use short-term therapy techniques and treat patients quicker or faster. This involved "a constriction in the number of visits and the amount of time I would see somebody. The major change was I felt pressured to get people better faster which may or may not be useful for the client. The implication is do it fast"

Therapist F felt that, especially with more chronically ill clients who more frequently require inpatient care, "People are coming out of the hospital sicker. Shorter hospital stays. People being medicated and closely monitored in a safe environment, that

is all gone. I am getting people who were in a hospital for five days and started to be treated with anti-depressants that take three to four weeks to even kick in. .” Therapist F finds that hospitalized patients are discharged less stabilized because of care denials.

Therapist F discussed the pressure to change her therapeutic techniques from an insight-oriented, family-systems approach to more “superficial, Band-Aid” approaches. She said, “The approach I used needed to be modified. I was doing more analytically-oriented work in family of origin. That model, I could not use as much. I went toward a cognitive framework, like Aaron Beck’s model.” The change was doable but less comfortable. She felt it was less helpful to clients because lasting change requires insight into problems and behavior changes following that insight. She added,

“I think real change only emanates from some insight. That to me is real change and help for the person. I consider the other approach, the brief psychotherapy models, to be like a Band-Aid. That gets the person up and running and back into the life that they pretty much have without making too many basic changes. If I get limited in terms of visits and I have ten visits, the treatment is much more superficial. I do not feel comfortable that the changes in their life are good and permanent changes, unless I continue in the situation and see that happen.”

Another theme to emerge during this interview concerned the effects of managed care procedures involving paperwork, fees, and clinical treatment time lost to paperwork and authorization issues. First, Therapist F discussed the actual authorization paperwork. She said, “The treatment plans actually are stupid. You put down somebody with panic disorder. My goal: to eliminate panic attacks, to assist client to develop insight into the origin of attack.” She viewed the paperwork as simplistic, cumbersome, and circular, adding, “And I got certified on the basis of those goals.” This she found laughable.

The second issues involved the qualifications of the people working for managed care companies and “interacting with people who have little idea about what you do and

needing to justify what you do on paper to these people." She discussed an interaction with a case reviewer who "was totally ignorant of what a clinical specialist or an advanced practice nurse, or what that was. I explained to her the four disciplines that provide psychotherapy and we happen to be the smallest group. She did not know."

Therapist F's patient was presenting with agoraphobia and panic attacks and "she said to me do you know anything about panic disorder. I said yes. I have been treating patients since 1986. It went from there." Therapist F found it inane that the certifying managed care clinician was unaware of her degree and clinical functioning.

An issue related to this concerns what Therapist F calls the "demeaning" nature of working with managed care. The above story is indicative of this issue. She continued, "There is a piece that is demeaning and I was implying that when I told you about my interaction with the lady. I have a masters in psychiatric nursing. I was director for a community mental health center. I've had a private practice for the past 15 years. For someone to say to me, do you know anything about panic disorder was quite demeaning."

Perhaps the primary component of this theme concerns the clinical treatment time, and by implication income or money, lost when Therapist F works within managed care rules and regulations. A contributing factor is the decreased fees reimbursed by managed care companies. She said, "It increases the time that you have to spend on a client and time is money because you have a patient hour and then you have another hour or two hours struggling on the phone with people, developing treatment plans, doing all of that. And even if they pay you X amount of dollars for a visit, that visit, that money that they are paying you is really for three hours of work rather than an hour."

Because Therapist F worked primarily from a family system's model, she spent much time translating this conceptualization of the assessment into the categories provided on the managed care certification paperwork. She said, "They want a mental status and stuff like that, a diagnosis and treatment plan. I get mental status and stuff in the first couple of visits but I do a genogram. That is short-hand for me and I operate out of that. It is hard to translate...When there is no involvement in insurance, reviewing the genogram after the person left and giving some thought and making a few notes, was enough for me to go on in terms of where we were going to go and how long."

It was problematic, difficult and cumbersome, to translate a genogram into the format that the managed care companies required. Therapist F found it problematic to try to fit patients into the diagnostic categories requested by managed care. She clarified this issue when she said "Translating from one to go to the paperwork and then getting the paperwork sent and getting back the approval, all of this stuff, I find pretty cumbersome. And time consuming where that time could be better spent with another patient."

A significant issue for this therapist concerned the ethical issues of privacy and confidentiality; what Therapist F terms "intrusiveness." She said, "I really think that is probably what I find most of all with the HMO's; the intrusiveness." It has always been Therapist F's practice to carefully guard client files and confidentiality. She said,

"I have always had a private practice model. If they want to come and view my notes, they would have no idea what these notes were about. I write snatches of conversation, vague notes. When it comes to any content, the notes are really sort of vague and could not damage anyone if they were known. I am not complaining that I want to go back to the good old days but years ago when you treated somebody, you alone had access to those records. Nobody invaded them."

Her comments express some contempt that managed care has access to private client information. Therapist F felt a strong need and obligation to keep client information as confidential as possible, resenting managed care's desire to do otherwise.

Therapist F touched upon other ethical. She said, "The biggy was confidentiality. Well okay, if you want to go the full ethical thing, autonomy is interfered with. And what is right in terms of treatment... You know, I was thinking about what I was telling you about limiting down the treatment and changing your treatment a little bit to meet the managed care requirements. There are lots of ethical pieces right there...that I am not comfortable with." The implied ethical issues center around the ethics of managed care's requests for changes in the course of treatment without intimate knowledge of a patient.

Therapist F's concerns about releasing clinical information to managed care extend to who sees the information and where it goes. She said, "Because I do not know who is there or how many people are seeing this or whether it is private knowledge." She had concerns about computerized clinical information and how private that avenue could be maintained. She an interesting example of this concern. She received a certification letter from a managed care company for a patient whose name, demographic information and summarized clinical information was included in the letter. However, the patient was not hers. The therapist had her same name but practiced 80 miles away.

It appeared that the insurance company "screwed up with their data bases because I received a check for services rendered to somebody I had no idea who they were." After telephoning the managed care company to rectify the matter, Therapist F received another check in response to which she phoned the patient and the therapist. During the last conversation, "We came to the conclusion that they must be consolidating data bases and

she tells me it has happened many times to her.” Relating confidentiality concerns to concerns about managed care personnel, Therapist F added, “I just have a sense these people are reducing their staff. They are over-worked or their data bases are screwed up.”

Second to the theme of intrusiveness, Therapist F took issue with the pressures from managed care companies to label people with diagnostic categories. This heated issue was related to the theme concerning managed care rules and regulations. Therapist F gave her opinion about labeling clients when she said, “I am not happy with labeling people to begin with. That is not my training. That is not where I come from.”

She described her concerns through a story about a client she has who was diagnosed with Bipolar Disorder 12 years ago. However, “We are finding now that she has a seizure disorder. I have never seen her manic. I have real questions about the accuracy of this diagnosis. The only thing I have seen is recurrent depression and maybe some panic disorder. She has been walking around with this label and I am not sure the label fits... What happens is the labels follow the client from one insurance to another and things get to be pre-existing down the line.” Therapist F believes that, in today’s managed care environment, diagnostic labels are often inaccurately applied to obtain care approval. This same client recently visited her psychiatrist, looked at his notes that she was suicidal but “she was not. The person said, that’s for insurance; justifies it at that.”

More pressing for Therapist F, however, was the implications she saw for clients who know of their diagnosis. Continuing the story of the above client, Therapist F added, “I could not even describe the damage this labeling has done. She spent years looking at everything she did as a symptom and everything she did scared her. It was a snowball. If she was a little bit angry or irritable, oh maybe I am getting manic; not that the kid had

just broken the television” She continued, “The degree of shame she has about this has been unbelievable and has had a tremendous impact on her life; on how she has looked at life” In Therapist F’s opinion, her client’s entire life has been colored by viewing her behavior, feelings, and thoughts through the lens of a symptom of Bipolar Disorder.

In response to the above concerns, Therapist F decided to withdraw from working on managed care panels. She spoke at length about this decision:

“I think it is a big rip-off. I have gotten to the point where I am a total out-of-network provider. I would never pursue being an in-network provider probably more than anything else because of myself, the paperwork, the cumbersomeness of it. I actually would take lower fees to justify not using insurance, If I have this person now going out of network, certified for a year and a half, I have time to work with this client.”

The time lost to managed care paperwork, losses of privacy and confidentiality and contempt for the idea that outsiders, without direct clinical knowledge, make treatment decisions has led Therapist F to leave that system, even with a reduction in her income.

Therapist F, however, cited the managed care’s reduced fee schedules as reasons to avoid working with them. This was only partially related to the lower pay scale; it primarily related to her belief that a decreased portion of funds are directed into patient care while large sums of money are salaried to managed care executives and used to pay all care managers. She said, “What they went after was the old fee-for-service stuff. But it swung so far the other way that I see them as the abusers now. I really would like to know, from an economic standpoint, how much more the HMO costs because of all these new people. How much that has eaten into patient care dollars. It is self-defeating.”

The following analogy poignantly highlights the issue: “They had on TV these big estates that the CEO’s of the managed care companies had. It is the same as you look at

your charity contributions and what was being looked at was how much money was going into the administration and how much of your charity dollar was really going into helping anybody. It is sort of the same thing. How much money is going in to fund all these new categories of workers. It is just a whole variation on an industry; like a big add on."

Therapist F said many of her clients felt similarly, especially with regard to dealing with managed care regulations and concerns about the privacy of their personal data. She said, "I see people who are purely cash people who have serious and persistent mental illness. I do not do insurance with them primarily because they do not want this stuff known." She believes more people are avoiding psychotherapy because of the difficulties related to managed care paperwork and the loss of privacy.

Therapist F found few positive outgrowths emanating from the managed care system. She took very strong issue with the abuses by physicians and psychiatrists who she felt were unrealistic about their fees. She said, "I think these people are totally out of touch with reality in terms of how they value themselves financially, and their services." She was angry that all professionals have had to pay a price for the abuses of upper management and does not believe professionals have stopped abusing the system. She sees the abuses taking a new form through benevolent behaviors to manipulate or beat the system and obtain care authorizations. She said, "I know people who are working the system and abusing it still. I do not think it has made that much difference in terms of the people who are abusing the system. They people have just learned the system."

Though future changes to the insurance system did not emerge as a strong theme in their own right, Therapist F had an innovative plan to change the current system. She said, "I am a great believer in a totally nationalized health care system. I should not say

nationalized; I should say socialized system. Socializing the whole deal would mean big, big change. I know there would be bureaucracy but, when you have that kind of system, you may be able to get more care to people, more of the care dollars into direct care. Whereas now some have none, it would create a balanced system.”

These changes would involve altering the salary scales paid to various disciplines. And would address the origin of the abuses in the behavioral health fields. Therapist F added, “I would look hard at physician’s salaries, as opposed to psychologists, as opposed to, and kind of work on, not equalizing necessarily. There always has to be a boat captain. But look, there are some people that make outrageous amounts of money.” Therapist F described a gradation in pay scales “more appropriate than what we see.”

Therapist F addressed a return to ethical business practices in her hypothetical insurance system; again recognizing the issue of abuses and accountability in health care. She added, “If it were capped in my ways, it would not need to be managed to the degree it is. The problem is you need some people with integrity to be involved at the top and throughout the system. I think in health care, there needs to be somewhat of a resurgence of ethical values and principles. It has gotten to be very much a money-making system.” In these last comments, she alludes to the “dollar-driven” business of managed care discussed by previous interviewees. Re-quoting an earlier passage, Therapist F said, “It swung so far the other way that they are the abusers. I see them as the abusers now.”

Composite Textural and Structural Descriptions

Theme 1: Managed Care Policies and Procedures- Impediments to Treatment

The rules and regulations of managed care emerged as a bane to all the therapists interviewed who viewed them as time consuming, restrictive, cumbersome, and without clinical indication. Therapist A said, "I have to live within a whole bunch of their rules and regulations and I have to accept the limitations," Managed care paperwork and phone calls was the first procedure causing problems. Therapist A said, "I have to answer to them in terms of even how I phrase what I put in my report. I just have more paperwork. It is really a great misuse of my time. Therapist F concurred, "There is too much paperwork. It is all a pain in the neck. All of this stuff, I find very cumbersome."

Therapist B also viewed the paperwork as a hassle. As a previous managed care employee, she said, "It is just ridiculous. There is so much paper involved and what does it really say? What does that really do? It is kind of like the government. I know what it looks like from the other side with all of these reams of paper coming in. I would waste days just looking through charts. I do not like that kind of bureaucracy with layers and layers of paper spinning between insurance companies and us."

These interviewees focused on the clinical time lost to processing managed care paperwork either via phone or mail. Therapist B spoke about being a provider on managed care panels, both due to the time element and the problem of clinicians getting "locked-out" due to member overflow. She said, "When I joined a group practice, it took me three months to get credentialed. I do not know how many people had to look at it but millions had to review my life. I have been on the other side and gone through clinician's

charts... and judging whether or not they are fit to be in managed care just from that.”

She added, “They only want a certain number of clinicians. That means that if you did not get in on the managed care panel when they were starting to fill it up, then you are locked out of that managed care company. You cannot take those patients.”

The cumbersomeness of the bureaucratic work was common. Therapist C added, “The paperwork is enormous. I can show you some [*treatment plans*] that are about six pages long for outpatient. You speak to somebody, file tons of papers. Some of them seem to have made them more cumbersome.” For Therapist D, the time spent on administrative tasks for managed care was very problematic. He said,

“Administrative time went through the roof. I used to directly bill patients and they would submit to their insurance. You start dealing with the insurance companies directly so the administrative time burden, that fell on me. It was tremendous compared to how it used to be. I do not care about the work itself but I was spending hours on the phone; hours. You could go out of your mind with that stuff. It really was just so frustrating I could not tell you.”

His frustration partially emanated from managed care personnel who did not follow-up on requests and the amount of time spent on hold waiting to speak with reviewers.

These interviewees were concerned with the need to authorize care and justify therapy to obtain approval for sessions with individuals they did not feel were qualified to make those decisions. Therapist F said the problem was “needing to justify what you do on paper to these people.” Therapist A similarly added, “I have to ask for a visit. I have to ask for three. I have to justify three more.” Therapist C’s thoughts mirrored these concerns. He said, “These guys are in a program to justify.”

The need to frequently justify on-going therapy was problematic for Therapist D who said, “I do not like to focus every three sessions depending on what the insurance

company wants to do." Therapist E spoke mirrored these concerns saying, "I think it raised my anxiety level in terms of doing clinical work because I was always wondering how many sessions I would be able to get for a patient." The focus, in these comments, is on two issues: questioning the therapist's clinical judgment and the mental energy that needed to be devoted to obtaining approval for continuing patient care.

Therapist A spoke further about care decisions by third party reviewers. He said, "Managed care dictates in a lot of ways. They dictate the amount of time spent. They dictate it by the way everything is stamped out in a mold." Therapist B added, "It is a treatment concern for a managed care company to dictate how many sessions people can have. They say we will give you ten sessions and, rather than have the clinician and the patient decide whether they need more, the insurance company decides." The idea of patient and therapist determining therapy length was consistent across interviewees.

The interviewees agreed there was a trend toward less management of outpatient therapy than inpatient care. Therapist C said, "It's much more with inpatient. It's like you are doing something wrong by hospitalizing them. There is this subliminal confrontative attitude." Therapist B added, "I think they are loosening up in terms of less management of outpatient therapists. We have been able to get more sessions without having to fight. I think they are finding out it is not financially worth it. They are not losing that much money on five more outpatient sessions. They are going to use their resources to manage the inpatient where they really do not want people to be there very long.

Therapist E has noticed two additional trends in terms of the justification process: more difficulty obtaining approval for Axis II disorders and less for child and adolescents patients. She said, "There is no allowance for an Axis II diagnosis. God know that is what

gets in the way of most everybody doing the things they are supposed to...I think the assumption is it takes longer to engage kids and adolescents. You tend to use a lot of para-verbal techniques to get to know them. And there is a lot of family involvement."

These participants viewed the documentation required by managed care as useless. Therapist F said this succinctly and facetiously, "The treatment plans actually are stupid. You put down, somebody with panic disorder. My goal, to eliminate anxiety attacks, to assist client to develop insight into origin of attack. It was sort of circular."

Therapist C spoke with similar contempt saying, "So I put eighty-three year old married African-American male with major depression, oriented to the three spheres, social problems are this, blah, blah, blah. It is ludicrous. Who cares about this. It is like I am in school." Therapist E felt "I do not think anybody reads these stupid things anyway."

For these therapists, there were a number of concerns about managed care personnel making care decisions for their clients. Therapist B said, "People who are reviewing treatment plans do not know anything they are reviewing." Therapist C related a story about a patient admitted to a hospital where the reviewer "wanted to know who the attending was going to be. They did not know that a psychiatrist was a physician." Therapist D would like to see this part of the system changed. He said, "They need to totally back out of this mentality where someone on the other end is going to make a decision. Most of the time, the person on the other end is not qualified."

For Therapist E, it was less being directed by others and more the belief that the people making the decisions were not competent. She added, "I have had experiences talking to care managers that were insulting in terms of the suggestions that would get made. People making these clinical decisions that did not know what they were doing.

The people telling experienced people what to do are recent graduates. It is not so much being told what to do but told by someone who does not know what they are doing.”

Therapist F spoke similarly about “interacting with people who have very little idea about what you do and needing to justify what you do to these people.”

Therapist F related an interesting story about receiving a check for a patient being treated by a therapist 80 miles away with her same name as herself. The paperwork she received disclosed the patients name along with some clinical information . This issue speaks to confidentiality but also to the credibility and reliability of managed care personnel. Therapist B, having worked for managed care, said,

“The paperwork goes to someone who hopefully is a clinician although it often goes to service people first. My experience was that it was not. I supervised people who were making decisions about treatment. A couple of them were licensed. Some were nurses who had absolutely no psychiatric experience at all.”

There was some question about the criteria used during the authorization process. Therapist B said that at times the decisions are arbitrary, adding, “So much is driven by, how can we get this person out of treatment fast rather than how can we supply the best thing for the person. I understand that, if they are paying for it, there is a limited amount of money to pay for things...but I think it is primarily driven by cost. It should be driven by something but sometimes it seems arbitrary.” No interviewee was aware of the origin of the authorization criteria used to make care decisions for their clients.

The process of diagnosing patients emerged as a minor theme of managed care regulations. There is an unwillingness to diagnose or categorize clients and the belief that, though helpful for directing treatment, it was not particularly useful. Therapist B called the process “dehumanizing...I think that it has become sort of rote; people are just sort of

a piece of paper." Therapist A exemplified this concern saying, "My problem is this. I do not like to put people into a category just to get them financially covered. I prefer to see everybody as different. Yes they tend to fit into some of the categories but not necessarily. I do not think it is most useful for them."

Earlier, in the individual narrative for Therapist F who also dislikes categorizing by diagnosis," an example was given of what she perceived as negative ramifications of labeling people. The case involved a woman who was diagnosed with Bipolar Disorder 12 years ago who came to view all aspects of her behavior as symptoms of this illness. In addition to believing that the diagnosis was inaccurate, Therapist F was concerned that the label would follow this woman for the remainder of her life. She added, "I could not even describe the damage this labeling has done to this client. If she was a little bit angry or irritable, maybe I am getting manic; not that the kid had just broken the television. It is unbelievable and has had a tremendous impact on how she has looked at life."

These interviewees were unwilling to both diagnose clients and focus on their presenting symptoms only; both requested by managed care to obtain authorizations for care. Participants handle this dilemma by manipulating managed care paperwork. Therapist B gives "the most benign diagnosis I possibly can. It is not a big conflict for me because I feel as though it is really not up to the insurance company to make that decision for me." Therapist E tends to "diagnose adjustment disorder with mixed emotional features one heck of a lot. I didn't give insurance companies diagnoses that were hugely accurate. As far as I am concerned, that is not the insurance company's business."

Therapist C says that "the entire psychiatric world does not believe that the DSM is a good thing because can you really define the human condition, human experience as

having six following nine [*symptoms*], for two straight weeks...It should not be so nebulous. Sometimes, if you are very specific, you miss out on the person, the humanity; the psychology element." These interviewees viewed diagnostic categories as restricting for patients in terms of accurately reflect the complete dynamics of the person.

A number of concerns factor into the anger and frustration these therapists have toward the rules and regulations of managed care, primarily, the amount of clinical time lost to the authorization process and the fact that the professional intimately involved with the patient is not able to make clinical decisions. Therapist C spoke of the numerous times his sessions were interrupted because of incoming phone calls from managed care reviewers. He was angry about reviewer's requests to cancel patients to accommodate the insurance company. He commented, "This is the time where you have to be available. It screws up my days where I have to speak to doctors and they take longer than expected and that pushes my patients back. It's hard to maintain a day's schedule."

Therapist D continued these concerns, saying, "I was spending maybe a day a week, on the phone trying to get paid for care they already approved. You can't work that way. I am dealing with the extra paperwork. It is invading my clinical time." When Therapist E does not have to deal with managed care, "It has allowed me more time to do specific training in terms of clinical reading." Therapist F commented on the time and money lost when dealing with managed care when she said, "It is tiring and cumbersome. It increases the time that you have to spend on a client and time is money. And time consuming where that time could be better spent with another patient."

There is resentment that therapists' clinical decision-making skills are questioned. Therapist A believes treatment plans are less helpful than managed care implies. He said,

“Why do I have to discuss my treatment plan of the patient. The proof needs to be in the pudding in whether the patient gets better.” Therapist B extended this concern: “What does the treatment plan really say about what is going on between two people in a session. I do not think you can put down on paper what is really going on. You can give indications of how the patient is doing but why do we have to go through all that when they clinician knows.” She added, “Therapy is an interaction between people. It is really standing with them where they are with things. How do you put all that down on paper.”

Therapist C admits the issue is about a usurping of clinical power but feels it is more that clinical care is dictated by uncredentialed people. He says, “It is the second guessing by someone less knowledgeable than you.” For Therapist D, the concerns is “these arbitrary treatment decisions that they make” apparently without empirical justification. Therapist F adds, “There is a piece of it that is demeaning. I have been in private practice for fifteen years. For someone to say to me, do you know anything about panic disorder, was quite demeaning.” The loss of legitimate control over the clinical process was quite disturbing to these therapists.

Theme 2: Monetary and Financial Problems with Managed Care

The second unanimous theme to emerge from these interviews was the perception of managed care as a financial bureaucracy; a profit-making enterprise whose regulations and procedures were designed to amass of money for the managed care organization and not to ensure optimal clinical care of the patients served by them. Managed care was said to emerge to curb escalating health care costs. As Therapist C stated, “The insurance

company will say they are the patient's representative, they are looking out for the well-being of the patient to protect them from the unbridled costs of medical care."

Therapist B believes, "It is one great big bureaucracy. A lot of money paying managed care companies to provide a service I do not even consider a service. How valuable is what they are doing? I think it is all so driven by money. It is all so driven by cost." Therapist A believed similarly. He said, "It is all dollar-driven, completely dollar-driven. There is no concern for the providers or the patients, none. I think they want to pay as little as possible. It is a business. It is now much more of a business."

Therapist C added to these reflections saying, "Managed care is a racket. Their mandate is to offer care at the lowest possible cost, in a way that does not jeopardize the company's pocketbook. We know that they do not represent the patient. Their bottom line is the money that the corporation makes." Therapist C felt managed care focused on psychiatry, who accounts for a large percentage of health care costs, and attempts to achieve cost savings by pressuring psychiatrists to use psychotropic medications in lieu of therapy. He added that managed care "will say in the long run it is more effective but the company is saving money because they bought eight thousand pounds of Zoloft."

Therapist D's comments on this theme focused on the apparent inconsistency of trying to save money with a business as expensive as managed care. He said, "There are studies done that the infrastructure to support managed care companies is so expensive that it is like a wash: the money they are saving by disrupting treatment is almost offset by all of the people they are hiring to manage it." Therapist F's comments were quite similar. She said, "I really would like to know how much more the HMO costs because of

all these new people; how much that has eaten into patient care dollars. I think it is a big rip-off." She watched a program about managed care upper management in which,

"They had on TV these big estates that the CEO's had. It's the same as charity contributions; how much money was going into the administration and how much of your charity dollar was really going into helping anybody. How much are the people at the top making. It's gotten to be very much a money making system. It swung so far the other way that I see them as the abusers."

Related to idea of managed care as a "dollar-driven bureaucracy," interviewees focused on the reimbursement fees managed care contracts provided. These fees were viewed as unreasonably low and, as a result, have impacted therapist's income and how they conduct therapy. Therapist A said that, when a provider contracts with managed care, "You cannot charge other than what managed care allows." Therapist B concurred, "The managed care insurance companies pay less. I do not know what it is now; it used to be 70 dollars for a social worker. Now it is about 50, 60." Therapist C commented that many of his managed care rates have not changed in a many years. He says, "You know, New Jersey has not increased their Medicaid rates in thirty, forty years." When patients fail appointments, he cannot charge them as he otherwise would to maintain the working relationship. He said, "Can I bill them? No. So there is no incentive."

Therapist D also talked about the "horrible rates of reimbursement" but found this less troubling than the interference with the therapy relationship. He said, "The one thing about the fee cuts, if they did not cut in on my privacy, I would not like it but if I wanted to make the same money I would just work an extra couple of hours." Therapist E left managed care because she "got tired of being paid miserably. What really aggravated me is I would get referrals that did not even come from managed care and I was forced to accept that network fee. It was really costing me money to be in managed care."

The reductions in income were bothersome to all of the interviewees. Therapist A spoke of this in terms of expenses and overhead: with the reductions in fees imposed by managed care, a professional is unable to make a living like they previously did. Therapist B said her coworkers discuss "making less money. Their income has been cut significantly. I mean, I make a lot less money." Therapist C realized additional losses in income precipitated by the extra office help needed to assist with managed care paperwork. He said, "The paperwork means, if I were really serious with it, I would have to hire another person. It would not be cost-effective."

Therapists D and E elaborated on the percentage of income cuts. Therapist D took, "40, 50% pay cuts without being able to negotiate that at all. When you take a fifty percent pay cut and in five years do not get a nickels raise, it is that kind of ridiculousness." Therapist E said, "My fee for individual therapy is 120 and managed care is charging 57. That is over a 50% cut." Therapist F viewed the income reductions relative to the amount of work she puts into a patient hour with managed care insurance. She said, "You have a patient hour and then you have another hour or two struggling on the phone, developing treatment plans, all that stuff. Even if they pay you X amount of dollars for a visit, that money is really for three hours of work rather than an hour."

Therapist A took offense that some managed care companies did not differentiate rates based on a person's degree. When he was a board member for a managed care company, he asked them to "reconsider their fees with regard to a difference between psychologists and social workers. They were paying exactly the same fee; LSW, ACSW, the same as Ph.D. I asked why can't you make even a five dollar difference. It is so much

harder to become a psychologist, so much more work goes into it. And the reason we kept getting was we do not have to." Managed care is perceived as overly arrogant.

For this reason, Therapists A and C will refer patients with managed care to a network provider for psychotherapy because of cost-effectiveness issues. Therapist D has had and continues to have difficulty being paid for approved sessions. He says this is "insult to injury. I am on the phone trying to get paid for five months ago." This, combined with the income reductions, became unbearable and contributed to his decision to abandon managed care systems.

Other interviewees expressed anger at managed care's refusal to reimburse for completed therapy sessions when care authorization, already perceived as inane, was not obtained. Therapist C has encountered this situation one a few occasions. He said, "If you did not get the pre-certification, I see the patient for nothing. They will not say it is just a matter of the paperwork you did not do. They say screw you; you did not get the pre-authorization, it is too late. This is the way they save money. Even when they review, there is no guarantee you will get paid."

Therapist C discussed referrals, directly from the managed care, where payment was still refused. He said, "They have called me to see a patient in a crisis situation. In both those cases, they refused to pay because, they did not have them in their computer. Their stand was that the doctor was responsible." Therapist D has also run into this problem for services rendered. He said, "Others have sent information saying I have not sent in all of the information on their outpatient treatment review form. They'll refuse to pay and we get into a fight about it. Their response is we'll send them to someone else."

Therapist E experienced ongoing anxiety about getting managed care paperwork in on time because “sometimes I forgot and they would not backdate things. The most aggravating part was they would have ten sessions through May 30 and you came to May 30 and you used seven. I would think, three more sessions. I would see them into June and, because you didn’t get the treatment plan in by May 30, they would not pay.”

These interviewees took issue with managed care’s denial of payment for services because of procedural technicalities. These examples are reminders of cost-saving tactics and arbitrary care decisions for contain costs. An increased reliance on medication, in lieu of psychotherapy, was viewed as another such tactic. Therapist A felt there was a push toward using general practitioners to medicate patients with mental health needs as a way to cut health care costs by enabling general practitioners to make care decisions without consulting a psychiatrist, “so they never reach the mental health professional.”

Therapist C has also noticed a push to “put them on medication beforehand. You may want to medicate somebody quicker” Therapist E concurred, adding, “I think they push people into medication too quickly because it is cheaper. I’m not shy of medication because I think it is indicated in situations. But there were times that I was told, if a patient didn’t have a medication evaluation, they would not pay for further sessions.”

Theme 3: Changes in the Treatment Process and Components of Psychotherapy

None of the interviewees in this study reported that they changed the manner in which they conducted therapy: they conceptualized, assessed, approached and created treatment plans that were consistent with their training and clinical judgment, despite managed care pressure to shorten care. However, the involvement of managed care did

create distractions for these therapists; the therapy process was burdened by the addition of being cognizant of managed care regulations and a need to rush through assessments.

The distractions created by working within managed care, though not effecting the framework with which these therapists work, altered the way assessed patient. The distraction was a focus for Therapist A who formulates patient issues into a different context for managed care. He said, "I think differently during the initial session. I am distracted. It is an extra factor for me to think about what they need within the confines of a managed care program. If someone is providing managed care, their objective is to provide an assessment as quickly and efficiently as possible."

Therapist B said, "I write it down differently. I see the patient the way I see the patient still. I take a different kind of history. I set it up a little differently." Therapist B is referring to the use of a genogram in her assessment in which she explores the patient's history in a non-threatening way. With managed care, her questions are more direct because of the need to complete the assessment for treatment planning after one session. She says it is "more direct. More cut and dry on the assessment I have to do for managed care. In fact, the questions are different."

Therapist C agreed there is a higher degree of directness, as well as a pressure toward promptness, in his assessments for patients in managed care. He said,

"It is like I would say list your problems in the order in which you think they are most stressful to you. It is more direct; much more direct. When I trained, we would not do anything for two weeks, just get to know the patient, medication free with the goal being to get a better understanding of the patient's illness. You have to, in a very brief period of time, do your evaluation and develop a treatment plan. It is like taking a sledge hammer to a fly; it is impossible."

The issue of using medication in lieu of treatment appeared to interact with assessment concerns; premature administration of medication was perceived as an impediment to proper diagnosing and treatment planning. Therapist C said,

"If you commit yourself to medicating somebody within a brief period of time and let's say they get better, the question you have then is was it the anti-depressant, was it the time, was it the interaction with them. Once you start pushing buttons quicker, you are losing valuable observation time. Once you medicate them, you blunt your ability to really know what is going on. We are treating right away. You are not going to get reimbursed unless you medicate."

Interviewees perceived pressure from managed care to complete all parts of the therapy process quickly and efficiently. Therapist E's assessments are two sessions long because "I gather a lot of information. I see a lot of kids; I do a whole developmental history so you can really figure out what you need to do instead of doing this ad-hoc stuff. I do not think people gather enough information before they start treatment."

Like Therapist C, Therapist E felt that successful therapy was dependent upon a clear understanding of the etiology of client's problems which in itself was dependent upon a thorough assessment. Therapist C added, "People rush into treatment before they understand the etiology of it. Etiology is more than do you have trouble sleeping. It is a whole other thing. That assessment is important" Therapists E and F felt that, not too infrequently, misdiagnoses and misdirected care result from incomplete assessments.

Beyond changes with the assessment period, or perceived lack thereof, there emerged a lack of clarity regarding the therapist's decision to change the techniques or approaches employed due to managed care involvement. There was agreement that they changed from a longer-term insight-oriented approach to a short-term, briefer one.

Therapist A's approaches remained unchanged but the therapy process was "effected by

the other master[*managed care*] they serve." Therapist's C and E also denied altering the techniques they employed; the latter said, "The clinical work that I did didn't change."

Therapist D maintained his treatment focus and approaches and simply "took treatment as far as it could go... You adhere to the model of treatment that you think is appropriate and effective and you try to work within the system as long as you can." If managed care further denied care, he negotiated fees with clients and continued his proposed course of therapy. Therapist F was the only participant who altered techniques because of the decreased approved length of therapy when managed care was involved. She said, "I found a constriction in the number of visits and the amount of time that I would see somebody. Consequently, the approach I used needed to be modified. I went toward a cognitive framework. I was doing more family-oriented and more analytically-oriented work; that model I could not use as much."

Like therapist F, Therapist E was more comfortable using an analytic and family system's model. She acknowledged moving toward a cognitive-behavioral framework, at least in terms of the treatment plans she provided to managed care. She said,

"I use a lot of cognitive-behavioral stuff within the context of a relational therapy. I might list cognitive management of affect and document using a behavioral treatment to deal with feelings. If there was obsessive thoughts, list the techniques of flooding and thought stopping, use behavioral experiment with different homework assignments, be fairly specific in those treatments."

According to this therapist, managed care rarely refused her treatment plans because of their specificity, concreteness and cognitive-behavioral focus."

For Therapist B, "The therapy piece is not different for me whether I am working with a managed care client or not; in terms of the substance of my work. The way I work with people is the way I work with people. I do not know if I could even change that very

much." Therapist B helped to clarify the apparent inconsistency between participant's denial that managed care effected their approaches and having hanged to using briefer models of care. Interviewees conceptualization of patients' problems, and the proposed course of care, remained the same but each abandoned tackling problems with preferred treatment approaches for brief models that fit into the approved therapy time frame.

What changes is the actual treatment plan that is instituted; though their conceptualization leads them to suggest a course of treatment they feel will be successful, in order to work within managed care, this plan is altered either in terms of problem focus on or to the depth to which each problem is addressed. This is the distraction earlier discussed by Therapist A which leads him to formulate "a tentative treatment plan that is going to fit the number of visits that they have available."

It is interesting that most of these interviewees felt that managed care reviewers did "not take a close look at the treatment plan," as Therapist B phrased it, and gained limited useful information from them. Therapist E's success with managed care authorizations stemmed from years of experience working on an inpatient psychiatric unit and her ability to write treatment plans in a format compatible with managed care. For these psychotherapists, their primary concerns about the impact of managed care on the therapeutic process focused in the area of the therapy relationship. Therapist B said, "I think what matters to the patient really is who is this person that they are sitting across from. Is this a person that I can talk to. Is this a person that will be understanding and that I can actually have some interaction with."

Therapist C was trained to spend two weeks developing the therapy relationship. He said today, "It is less free-ranging. You get to know the patient less in their free-

ranging environment. It impacts the therapeutic relationship." When working with patients in managed care, these therapists found the relationship adversely effected.

Therapist A said, "I become a health care provider rather than a physician. They become a covered life rather than a patient." The dynamic of the relationship is altered by the factors added to the therapy by managed care's involvement.

Therapist D spoke most cogently about the impact this caused. In the context of refusing to disclose patient's private information, he noted their response to be,

"We'll send them to someone else. Now, that pisses me off further because this is not like buying shoes and you just have another clerk come to the aid of the consumer. You are provider D and if provider D does not provide the information, then go to provider E. That is another way that they devalue the treatment. You are interchangeable, cogs in the system. There is no thought about transference, management of transference and the importance of the therapy relationship as a therapeutic tool."

Therapist D further stressed the need to have time to develop the therapeutic relationship:

"As a clinician you well know, there are things I do not find out about certain patients for a year, two years, three years. It is because they do not feel safe up until then. It is a ridiculous system. It attempts to force people to come out with everything right up front, before they have any relationship."

This issue was important for Therapist E as well. She spoke of it when explaining why she changed from a strict analytic approach over the years. She said,

"I do not think analytic work works. It works because of the nature of the relationship and a therapist's ability to help someone empower themselves. I do not think you help somebody empower themselves without any interaction. I do much more relational psychotherapy in terms of what goes on between me and the patient. Many people are very compromised inter-relationally. You have to build a positive transference before you can get into their negative stuff."

The significance of the therapy relationship is evident in the following passage from

Therapist E as well:

“If you have a good therapist who is related and intuitive and has a positive regard for people and has a good sense of their own boundaries, they can learn lots of techniques that can be helpful. I don’t believe, if you take a therapist who does not have those qualities, that no matter how many techniques you teach them, that you cannot have a good therapeutic outcome.”

When managed care is involved, the therapy relationship cannot be adequately developed because time is needed to build positive connections with patients. Therefore, in addition to the other changes to the therapy process, a weaker therapy relationship means all of the factors flowing from it render the those components of the treatment weaker.

The most relevant part of this theme was a general consensus that managed care seeks to make the therapy process “efficient,” as Therapist A phrased it, by decreasing the length of care: if therapy does not continue beyond a prescribed number of sessions, the cost is naturally contained. Questions arose as to the decision-making criteria for shorter outpatient care; whether it was the efficacy of short-term treatments, expenditure, profit-enhancing activities for the managed care companies, or a concern that patients were being taken advantage of by mental health professionals.

For Therapist A, this means getting “the patient in as infrequently as possible for as short a period of time as possible. You have to condense.” Therapist B acknowledges there has been a change in “the amount of time I end up seeing somebody. People come for maybe five or six sessions instead of extended periods of time because they can’t get appointments. Those with managed care spend much less time in therapy.” For her, managed care schedules new patients in slots that belong to other managed care patients; as such, these latter are not seen weekly, even when indicated, and often do not return.

The pressure or push for shorter, briefer care led Therapist A to notice a shift among psychiatrists toward seeing more patients for fewer therapy minutes, to counter the reduced reimbursement fees from with managed care. He added,

“A lot of the managed care companies will pay you the same amount for eight minutes as they will pay you for 45 minutes or an hour. They literally give you incentive to see more patients within your time frame. I think the pressures are very great and the pressures change what you provide and how you provide it. What those changes are is a function of the person under the pressure.”

Therapist A believes managed care wants therapy to be provided by the cheapest therapist; because of the fees charged by psychiatrists, managed care rarely approves therapy sessions with a psychiatrist. These pressures have effected the manner in which Therapist C approaches patients, especially those who need hospitalization. He said,

“You may not want to put them in the hospital as quickly. You say maybe I will try to keep them out of the hospital a day longer because you are saying in the back of your mind, this way I do not have to get a pre-certification, I do not have to deal with the reviewer on the phone. The average length of stay has gone because you approach all patients that way. It becomes a different mindset.”

Therapist D felt pressure from managed care “Constantly giving the message that treatment was going on too long. You feel like you are committing malpractice of you have a patient for a year.” Therapist F reiterates the perceived pressure for shorter care. She began this interview by saying, “The major change was I felt pressured to get people better faster which may or may not be useful for a client. I found a constriction in the number of visits and the amount of time that I would see somebody.”

These interviewees have noticed a trend with managed care to use EVT, though they do not label them as such; they use terms like time-limited, brief or structured therapy. For example, Therapist A says, “You are never going to feel really secure other than to follow exactly what managed care tells you. If they fit these criteria, five out of

the top six, then this is the diagnosis. If this is the diagnosis, this is the first thing you try. If this does not work, these are your two options. You cannot practice, every human being is different." Therapist B has also noticed that the approaches she uses are "much more clearly monitored, much more clearly defined, with more cost-effectiveness."

Therapist D directly addressed the issue of shortened therapy in the following. In this quotation, he discusses the appropriateness of shorter-term therapies but only after careful screening and when clinically indicated. He said,

"There were people who talked about short-term therapy but it was not for everyone. For them, the short-term therapies were still six to twelve months not ten sessions or less. In times of war, when there were damaged people coming back, they tried to maximize the amount of treatment. But, they were selective about who was appropriate; it was not an arbitrary number of sessions for anyone. With managed care, they want ten sessions for anyone. It cannot happen."

Therapist D took issue with managed care's indiscriminate use of short-term therapies as a cost-effectiveness measure. He was angry that analytic or dynamic work is not advocated partially because it cannot be quantified like direct, concrete therapies.

Therapist E expounded on the concern about care guideline criteria and the inability to neatly fit each person into a prescribed treatment plan based upon them. She said, "You can give them the recipe and they can say that is satisfies the care guidelines for a specific diagnosis. But, nobody can even quantify the other [*therapeutic factors*] much less put it on a piece of paper. It has gone too far. I think they say, these are the guidelines for treatment for major depressive disorder, the medusa, blah, blah, blah, and this kind of behavioral treatment and everybody has to fit into that template."

These interviewees were unsure of the etiology of these strictly determined proposed treatment plans and their usefulness for individual treatment. Therapist D

believes they grew out of financial concerns not clinical data. While discussing his disappointment with NJPA and APA for urging psychologists to embrace managed care, he said, "I was starting to feel like I was sort of out on a limb without any support because I felt NJPA and APA, early on, were supportive of the short-term therapies and sort of abandoning long-term work under the financial pressures."

In their own way, each participant called the indiscriminant use of time-limited therapies "managed care psychotherapy." It was consensual that managed care therapy was Band-Aid therapy and negative opinions about the usefulness of this approach to treatment abounded. Therapist A said, "There is a triage attitude. I do not consider managed care therapy psychotherapy." Therapist F considers "the other approach, the brief psychotherapy models to be like a Band-Aid that gets the person up and running and back into the life that they pretty much have, without making too many basic changes. If I get limited in terms of visits, the treatment is much more superficial. If I have this person now going out-of-network, certified for a yea, I have time to work with this client."

Therapist C defined the dictated therapy structured, crisis-oriented care. He said,

"They want psychotherapy for maybe six or eight visits. You can't really do very meaningful, insight-oriented work because it is very contemporaneous, very focused, very here and now. You are thinking differently. You are thinking of specific problems, specific goals. It is not time-limited; it is crisis-oriented. Longer-term problems, you deal with it through crisis. We probably offer varying degrees of symptom relief. It has redefined what gets treated by clinicians today."

Therapist D also equated short-term work with crisis-work. He said, "Absolutely short-term work, definitely. I never took patients on under the pretense that I accepted it because I do not know anyone that can be helped in ten sessions with a serious problem.

A crisis-management situation absolutely. Trauma cases, absolutely. The spirit of the times was definitely moving toward more superficial interventions.”

For Therapist B, providing therapy within the regulations of managed care means behavioral or supportive therapy. She said, “I would work in a more solution-oriented, problem-solving way for somebody that I knew was only going to be short-term. What can we do if we only have ten sessions. What is it that you want and how can you get to that here in therapy.” She sometimes alters her chosen approach, systemic, when she knows therapy will only be short-term. She added, “Let me take time to solve this particular problem. Sometimes, I would deal just with behavior. I do not think it works. I do not think that is how I really do therapy.”

The issues behind these concerns are the length of care and the focus of care. The interviewees prefer to focus therapy on the development of insight. Because of the factors they perceive as instigating successful outcomes, the therapy they practice is longer in nature than that approved by managed care. With a limited number of sessions, they feel the therapy process becomes more superficial and Band-Aid in nature; lasting changes come when new behaviors are rooted in deeper understandings and thoughts.

Therapist D was very vocal on this issue. Rather than change the approaches and goals he developed, he abandoned working within managed care regulations. He said,

“That was actually the impetus for me to get involved with formal psychoanalytic training myself. I want to be with people who understand the value of long-term therapy and the need to go longer to get deeper. When I had really had it with managed care, when I was jumping off the panels, I got into formal training. It effected me that way. That was the group I want to be with; the psychologists, psychiatrists, and social workers that do the kind of work I want to do.”

Therapist D continued his reflections about long-term therapy later when he said, "I started to feel like I was doing something being interested in long-term work. I wanted to formally affiliate with people who still saw value in long-term work" He chose to exit working with managed care rather than change his therapeutic focus to something he felt was not clinically indicated. He added, "I work the way I know I want to work and the way I think needs to be done." Therapist E felt similarly, though she often presented cognitive-behavioral techniques to managed care. She said, "I do not do short term work. My practice is more longer-term, not for six, twelve sessions."

The general agreement about a need for longer therapy than managed care often approved was out-shined by a stronger belief that insight and depth, cultivated with time, was the goal of therapy and produced lasting change, providing clients with tools to manage future problems independently. Therapist A was the strongest advocate of the need for developing insight. The following quote exemplifies his convictions. He said,

"You need them to develop tools to deal with whatever problems they are having so that they can work through the problems when the problems come up again. It does not come out of a bottle. I am trained in Freudian analysis. I use its understandings. I believe in insight-oriented psychotherapy. I believe that needs to be part of any process if there is going to be growth and change."

Insight development is necessary for successfully and permanently eliminating problem behavior patterns of behavior. Therapist A went on to say,

"If someone has the capacity for intellectual and emotional insight, they can grow. They can change the way their life is. They can be happier. They can be healthier. I think they need to have that opportunity. It is much harder; harder within the time constraints and the financial constraints."

Therapist A admits that happiness would not be an authorized treatment goal in today's managed care environment because "they are not going to want to pay for it."

For Therapist B, the same connection between depth, insight and longer-term work exists. She said, "With someone I knew who could be really long-term, I might work in a more analytic way. It takes people time to get to all the stuff that has been there for a long time and probably ten sessions is not going to do it." For her, without managed care, "you have the luxury of going in a lot of different directions which you might not be able to go in, more underlying problems. You might want to go back to their family of origin. You might not be able to get very much out of it if you only do it a little bit."

Therapist C discussed the time needed to develop insight. He saw long-term, insight-oriented psychotherapy as "a very valuable contribution to our behavioral repertoire. Psychotherapy is any interaction with a patient but I am talking about a more intensive, regular, ongoing psychotherapeutic process. Insight is a laudable goal that requires much more intense, sustained treatment. I am much less likely to do that if it is a managed care patient." Therapist C felt a symptom focus is less effective because "you may get relief from that episode but I am not sure how, over the long-term, that will help you deal with other issues and adversity. I am not sure how that might change your coping strategies that led to this particular incident to begin with. It is a long process."

Therapist D held similarly negative opinions about the indiscriminate use of short-term therapy. He tells his patients,

"If you are interested in quick solutions and answers, I can help you find someone else but I am interested in understanding some of the deeper causes so that, not only you get through this situation, but possibly you can prevent getting into other problems. I do not know anyone who can be helped in ten sessions with a serious problem; long-standing problems. I do not even know how you could work in ten sessions to do something about character pathology, psychosis, mood disorders."

Therapist F is also more comfortable working from an analytic framework, though it is not the formal approach that she uses. She too supports the need for the development of insight. She said, "I am more comfortable with a family slash analytic model because I think real change only emanates from some insight. You have some patients who gain some insight but never do the work to make the changes in their lives they need to make. But, that to me is real change and help for the person." Similarly, Therapist E believes in the need to "empower people to help them with specific things."

For these therapists, managed care has effected a number of the components of the psychotherapeutic care they provide; from the assessment process and the use of medication to the focus of the actual therapy and the length of care provided. It was general opinion that managed care has effected these issues in detrimental ways; beyond the positive change engendered by pushing therapists to be more cognizant of the techniques they use, they believe that patients are not receiving sufficient long care to enable them to permanently change maladaptive thoughts and behavior patterns.

Theme 4: Impact on the Person of the Therapist Working with Managed Care

The overriding, strongest theme to emerge from this analysis concerned ethical issues for the therapist working within managed care systems. These concerns range from therapist autonomy, and providing proper care to assure client well-being, to issues of confidentiality and informed consent. Confidentiality was the primary ethical concern. Each of the participants was concerned about disclosing confidential patient information to insurance companies or any individual outside the treatment dyad. These therapists revealed that patients had similar concerns about the privacy of personal information.

Therapist A brought up this issue when discussing audits conducted by managed care. When this situation arises, "I cannot block out anything that will prevent payment. I will block out anything that will compromise confidentiality." Therapist B extended these thoughts, "There is less confidentiality with managed care. There are always some confidentiality issues that insurance companies have access to their records." Therapist C went on to discuss these issues with more emphasis: "What about showing a patient's records. What about issues of privacy, confidentiality, where did that go. That is a joke."

Therapist C continued about his feelings toward having therapeutic privacy invaded. He said, "You may write a note in the chart and think it is sacrosanct but it is not because different reviewers look at the chart." Therapist C added, "The insurance company not infrequently asks for, they want to review your notes to see if they conform to the diagnostic code or the treatment code. You have to send them your progress notes to some of these insurance companies; these managed care companies."

For Therapist D, the confidentiality issue blended with issues of privacy in overt ways. This therapist discussed this in the context of changes in requests for information that have developed since managed care has fully blossomed. He said, "The intrusion on privacy was tremendous. You went from basically just having to provide dates of service, CPT codes, cost, diagnosis. All of a sudden, you have to provide all kinds of clinical information." Therapist D later added, "The violation of privacy is probably the main thing. A number of years ago, they did not really intrude on the content of it. You might put down a diagnosis and they did not know anything more about the patient than that from me." Today, insurers want history and details about current and past problems.

The concerns were similar for Therapist E who called confidentiality "the over-riding" issue for her. She spoke about how she handled managed care requests for information she believes is private. She said

"I would try not to list specific personal details and speak in very general symptomatic terms. I didn't believe that insurance companies should know all of this information about people. I would censor it and I would only give the bare minimum that I needed to get sessions. I would guard my patient's rights. I always felt like I was the patient's advocate and I would not do anything to compromise the patient's well-being in terms of information given to managed care."

Therapist E further guards patient information by always mailing paperwork to insurance companies due to her concern that faxed papers can be viewed by unintended parties.

Therapist D, elsewhere discussed under the New Jersey Peer Review Law, refuses to disclose pertinent private patient information, choosing instead to battle with insurance companies rather than breach patient confidentiality.

Therapist F also kept personal information to a minimum when she dealt with insurance companies. The content of her notes are intentionally vague and unrevealing if seen; they only contain catch phrases or incomplete sentences whose content are known only to her. Therapist F had strong concerns about privacy. She said, "What I find most of all with the HMO's is the invasiveness; wanting treatment plans, wanting updated progress stuff. She later continued, "I do not know how many people are seeing this or whether it is private knowledge. I am not complaining that I want to go back to the good old days but years ago, you alone had access to records. Confidentiality was the biggy."

These interviewees were concerned about what the breach of confidentiality or privacy would do to the progress of treatment and patient well-being. Therapist B said,

"There are always some confidentiality issues that the patients have. I do not like thinking that someone who is not even a clinician necessarily would have access

to my records. I think some patients do not get involved in therapy right off the bat if they think you are sharing information with people. Some people feel very strongly about having their records just being out there. Mostly, patients are concerned about who is seeing their personal information and where it is going."

It difficult to provide patients with any assurances of confidentiality. This is perceived as having a detrimental effect on the therapy relationship and process. Therapist D voiced these concerns saying, "I am more interested in the distortion in treatment that is created by demanding all of this personal information. I certainly don't trust what they do with the information. I think if I were to go into treatment now and I knew the information that was going to be reported, I would be much more guarded than I would naturally be."

No aspect of the disclosure of information, for treatment authorization, was perceived as supportive or beneficial. The overall belief was that managed care's requests for information were detrimental, useless and impediments to treatment. Each therapist had their own ways to try and maintain the confidentiality of their patients while continuing to attain insurance benefits so patients could continue with psychotherapy.

Confidentiality and privacy were not the only ethical concerns interviewees addressed. Therapist A took strong issue with conflicts of allegiance between clients and managed care; the therapeutic dyad is now a triangle because of the closely monitored financial backing of the insurance company. Therapist A said,

"If I deal with managed care, then my fiduciary responsibility is to the company rather than to the patient; it is business where doctors are allegiant not to their patients but to the business. If I charge the patient, then my allegiance has to be to the patient. I was trained to believe that my fiduciary responsibility was only to my patient and my patient was responsible to pay my bill. Fiduciary responsibility is to whoever is paying them and patients are no longer paying them."

This triangle between therapist, patient and insurance company was further addressed by Therapist C who said, "The doctor has been trained as the ombudsman of the patient. He

is trained in the service of the patient. What has happened now is very insidious because now both the doctor and the patient are at the service of the insurance company who could not give a squat. There is a change in the dynamics; there is a third party involved now here." Therapist E voiced similar concerns about "a triangle where there should just be a dyad." Each therapist tried to maintain allegiance to clients but experienced a conflict created by managed care involvement; there was anxiety with the perceived ethical violation, in addition to the extra work and energy expended for the therapist.

Because of the perceived threat to privacy, concern about maintaining informed consent, and a desire not to let resentment toward managed care enter the treatment relationship, Therapist's F and D made the authorization issues part of the treatment. Therapist F stated, "The way I managed it was to say that I was going to tell the patients about these documents, tell them what I had to inform the insurance company; make sure they knew. I would never communicate with anybody, anywhere, without fully informing the patient and telling them what I discussed." In this way, she felt patients could assume responsibility for their care decisions. Therapist D concurred and said,

"To keep myself from getting totally resentful about it, I would make it a part of the treatment; make it a shared problem. It is information that is being released about you; you need to take responsibility for it. For the patient to make a fully informed consent, they should have total control of the information. I want them to know what they are providing. That way, they were in total control of that process. So that their right to privacy was in their total control."

A part of the underlying issue for these therapists was a perceived threat to their autonomy; the ability for the treating therapist to make care decisions about clients whom they intimately knew better than any clinical or non-clinical insurance personnel. The perception of intrusiveness centered around outsiders trying to make care decisions that

often were at odds with the clinical judgment of therapists. Interviewees believe that, ethically, psychotherapy decisions belonged within the therapy relationship where, as Therapist D said, "we decide together how much treatment and the clinical issues throughout; not some third party" who is not privy to the intricacies of the therapy.

Other effects on the therapists emerged in these interviews. The first of these centered around treatment session time; therapists working for managed care attempt to make up for income lost to reduced fees by cutting down session time. Therapist A said, "I do not try to squeeze as many people in a day here as I can. I have peers that wind up seeing patients, they get the same compensation whether they see them for six minutes, eight minutes, 15 minutes, or 45. I do not see anybody for less than 45 minutes. I do not do any of that managed care stuff to generate dollars."

As a psychiatrist with a psychotherapy practice, the above comments are directly relevant for Therapist A. For Therapist B, a social worker, the issue is more one of condensing on the length of treatment because of capitation rates. She said,

"They would pay clinicians, a social worker, a 100 dollars for three sessions. Now if you could treat the patient in one session, then you got a 100 dollars for that hour. If it took you five sessions, then you were collecting 20 dollars an hour. This is how they manage treatment; get them out of there fast."

She added that, in turn, the therapist ends up

"very concerned about money. If you really think that it is going to take you longer than one session to work with patients, which most patients do, then you are not really going to make very much money. If you need to make a 100 dollars an hour to live, you need to have enough hours to make money in, then you have to get a patient out of there really fast. The treatment becomes driven by money."

Therapist E confirmed the thoughts proposed by Therapist A when she said, "I also think some of these psychiatrists can pack a whole bunch of med evals into an hour

and I know they do not see these patient for 15 or 20 minutes. They can chop them in and chop them out." Therapist F believed similarly. For her, psychiatrists, because of the nature or goal of functioning as a medication monitor, can see a number of patients within one hour for which they bill full session fees. She held contempt about psychiatrists who practice this way because of the negative effects on quality of care.

Because of the above, therapists have increased their case loads to try to maintain income level. How this impacts the outcome of therapy is unclear but, as Therapist A said, it will have an impact on the quality of services provided. He said,

"I cannot carry 400 active cases like a lot of people can. I will not know one patient from another. So I have to limit the number of patients, the number of sessions that I have. I average seeing six, seven patients in a day. Nobody gets less than 45 minutes. There is an incentive, by the HMO's, literally to see as many patients as you can. You can make a lot of money working for the HMO's if you play it right. But this is not a game; this is people's lives."

In this atmosphere, therapist availability or accessibility is effected, quite literally at times. Therapist C said, "I will not say what I do but it has been known that, if the doctor has a certain percentage of managed care patients, then their accessibility to him might be different. You might have a patient that is managed care that you would say, I can give you an appointment in three months or something like that. You might want to delay getting involved. I think that a doctor may be less accessible to the patient and even be less accessible to that patient's needs. They might not get them in quickly to be seen."

For Therapist A, similar issues arose. He said,

"My patients know I am accessible twenty-four hours a day, seven days a week. I limit the amount that I carry and I try to be a doctor to my patients. The more managed care patients that I take or anywhere I have to justify or anywhere I have to lower my fees, that means either I have to take on more cases or it means that I have to provide less service to the cases that I have. Even doctors that are really

good doctors are getting squeezed dry. They are just not emotionally available the same way they were. Even the ones that want to be can't be."

For these therapists, the disincentives of managed care fees and regulations lead them to develop a less than therapeutic attitude toward patients, especially those with managed care. In a desire to avoid the problems with managed care, the patient is shuffled aside.

This issue is evident in the following quote from Therapist C who was discussing counter-transference implications for patients in terms of emotional availability. He said,

"If you get ticked off at the system, then it spills over into your relationship with your patient but not necessarily only your managed care patient. It may spill over into the way you interact with your patients. How that effects the judgment; that is hard to define. I think that the doctors, a lot of them are pretty upset. If anger is an element, then it is going to effect your transference, the way you interact with patients. It effects all of the patients because sometimes it is hard to differentiate a managed care patient. It may be that is how you start offering care."

Therapist F seemed to be able to avoid any spill-over to her clients; managed care or otherwise. She said, "People get benefits either through their job or whatever... When it comes to relating to clients, no it does not effect me. I do not work differently with cash patients versus the insurance people with their paperwork." Even Therapist A who was quite angry at managed care restrictions said, "there is no difference, a patient is a patient is a patient. They are not a covered life because they are managed care. It is still a patient. I try to have there be no differences. They still get the same service."

A difference or issue did emerge where therapists felt psychologically distracted by the regulations of managed care, beyond the above themes. Therapist A said,

"If I have to worry about what is going to get them compensated, I am spending too little time in trying to get them well. It means more time devoted to thinking about the justification. If I get caught dealing with managed care patients, I am distracted because part of my thinking, part of my approach needs to be devoted to justification rather than me getting to the bottom of what is really going on see

where it plugs in and how I can utilize whatever they are giving me so that it is beneficial to make connections for them so that they can grow.”

For this therapist, the issue is more than craning to fit the patient into managed care categories. He continued with this concern,

“It is the need. Whose need am I looking to fill. Am I looking to justify to the company or am I really trying to understand the patient. You can’t serve those two masters and serve them fully. To really try to serve the patient, I have to be really listening to the patient and not have one ear craned for what other master I have to serve. All of us are distracted that are providing managed care. I think managed care puts the provider in a very conflicted situation. There are different things they have to satisfy. As much as it is more concretized in terms of what to do, it is becoming actually more chaotic.”

Therapist D agrees there is disruption to the treatment process caused by the distractions.

He says, “I did not purposely do it but it was a constant presence so that you are always dealing with, is there time to file the paperwork, what should we write. It became a focus and a tremendous disruption.”

Earlier, Therapist E discussed heightened anxiety from working within the managed care system. She later said, it was

“because I always felt like it was hanging over my head. You had to be aware of each session, how many you were using, and when you needed to get a treatment plan in again to get paid. That was onerous to me because I would be in a session and realize, I would look down on the little checklist I had and I would think, here I am into this session now I have to get them to back-date it.”

Therapist C sees the pressures and distractions with inpatient care as well where “There are subtle cues that they want to get the patient out of there quickly too. They do not want to be stuck with a bigger bill.” The financial, and resultant clinical, restrictions due to managed care has effected larger care facilities who, because they are legally responsible to provide for patients safety, end up providing care for free after managed care denials.

Pressure to provide quicker, less expensive care effects all parts of the care spectrum.

The end result is that therapists working within the managed care system lose the ability to intimately know their patients and develop a working relationship that facilitates change. Therapist A added, "I have seen patients, that have been with managed care therapists for over a year. I know the patient better in one visit than they [*managed care panel therapists*] know them in a year. That is disgusting. For the initial visit, I am going to have the person stay until I can understand exactly what is going on. I know my patients." For this therapist, professionals who work within managed care systems do not have the luxury of such intimate knowledge of their patients.

There is a sense of helplessness that results for these therapists when they work with managed care and the constraints associated with it. They find it harder to provide the kind and amount of care that they believe will help a patient to wellness. These issues have had an impact on their responses to managed care. Two therapists discussed intrapersonal effects that are relevant here. Therapist A spoke about feeling "more and more helpless given the constraints to provide care." Therapist C also spoke about feeling "little incentive" to battle managed care for a continued approval when he expects that care to be denied. He added, "I know they are going to turn me down so why screw up my day. Why do I have to get bent out of shape. I know that I am not going to win."

Theme 5: Repercussions on Patients from Direct Involvement with Managed Care

A number of issues emerged related to interviewee's perceptions about managed care's effects on clients. The first was client investment relative to small co-payments. The consensus was that patients in managed care are less invested in the therapy process because of the substantially lessened financial burden; therapy is usually not pro-bono

because the financial burden, so to speak, to the client effects the degree to which they will psychologically invest in their own treatment.

Therapist A addressed this issue when he said, "I do not think time becomes as precious because I do not think each session becomes as precious to them if they are not paying money. There has to be more of a burden to the patient, financially, emotionally, intellectually, it all goes together." Therapist A further elaborated on the financial factor when he said, "Psychotherapy becomes a bargain; with a small co-pay, it is a bargain. At fifteen dollars a pop or five dollars a pop, what difference does it make to them."

For Therapist C, the effects of minimal payments were similar. He said, "If you know that you are going to see somebody for ten dollars, then that has a certain appeal compared to somebody that you are going to see for 100 dollars, even if you have been seeing that guy for seven or eight years. So, they go with the cheaper route." Therapist C connected this issue to the therapy relationship, adding, "If somebody can just switch... as soon as their insurance switches, it is like switching a friend or switching a mate; you establish a relationship. I have had people who have done that, just like that."

Therapist D had similar thoughts and related them to the change from a clinical to a consumer model of treatment; patients shop for and treat therapy like shopping for any other item. He recognized detrimental effects from the decreased financial burden with managed care. He said, "I have had the sense there are people who would sample treatment or probably even would have never come in because they come in and they flip their ten bucks at you and they leave. The people come in with the mindset that it is a ten dollar investment... You see some one who has seen three therapists in the last two weeks because they are trying to find a therapist, like they were going to try out cars."

There was agreement that money plays a role in the therapeutic relationship and process; different for each client depending upon their relationship to money. The interviewees believe that the lower co-payments with managed care have altered clients perception of and investment in the therapy process. The general thought is that it has diminished the client's willingness to psychologically participate in treatment.

Therapist A touched upon some of the relationship factors that may be interacting with this financial issue that effects client's investment in therapy. He said, "A lot of people stumble into this office that have been through managed care offices have no idea what to make of this office. They cannot figure out where I came from. The fact that I do not spend the entire first session getting them to just fill out a form and asking them a battery of questions that I have to in order to be able to get them the next visits."

Most interviewees believe managed care restrictions on treatment kind and length, do not motivate clients to invest more; they interfere with the process of therapy. Their clients have commented about the frustrations from dealing with managed care that create a form of helplessness in them. Therapist B discussed problems patients had when telephoning managed care companies to rectify billing, referral, and authorization problems. Therapist D discussed his concerns about the paperwork for managed care reimbursements and authorizations. He added, "I have some that say why do I have to do it. It was clear that they would rather know nothing about it and not get involved with it."

Therapist B was ambivalent about whether or not the time-limitations and lower co-payments, imposed by managed care, facilitate or inhibit patient's investment or progress. She said, "It is not necessarily bad, under managed care, that they pay less. I do not know if that makes somebody more or less motivated but you will come more if you

have to pay less. If you only have to pay ten dollars a session, then maybe you will use every single session that they allow you." She added, "I think sometimes when it is time-limited, people work harder. Some people just kind of let it drag on for years and years. I certainly have some long-term patients that I do not think are very invested in therapy"

In stark contrast, Therapist D felt this issue was moot because it presumes that clients have conscious access to all psychological material and can thus manipulate their participation at will. He said, "I think that is nonsensical. That is telling me that you think everything is conscious and available for the patient to work out which I do not think is the case. It is not like a physical thing where instead of running two miles a day, I will run ten because I have less time to train. I do not think that is a meaningful concept."

Therapist D believes the time-limited nature of managed care therapy has diminished client's motivation to invest because they have been led to expect quick solutions to problems; but, he believes many non-managed care clients resist treatment as strongly.

For Therapist D, the issue was more one of his own satisfaction: it is difficult to work with a person who does not want to invest themselves in the therapeutic process. He added, "I would rather have someone who is serious about doing something about what is going on than ten extra sessions a week of people who are just coming through. It is more satisfying to have someone who thinks they have problems they want to get some serious help for than to have people come in and be sort of casual and cavalier about it; who want you to give answers to complex questions in an interview."

Generally, the interviewees had a negative attitude to all aspects of working with managed care, including the effects on the therapeutic process. There is resentment and anger about forced changes to the therapy process that are not seen as beneficial.

Therapists must alter their working approach to ones they do not consider to be potentially successful or optimally helpful. There is also the perception that clients have developed unwanted or unreasonable expectations about what therapy can offer.

Therapist D has noticed two additional insidious changes in client's expectations and behaviors since the advent of modern-day managed care. The first concerned the expectation of quick cure. Therapist D said, "It puts this negative dynamic into the treatment where an expectation was built up that in six sessions, that even the most complex problems would have been solved. It has an effect on the patient who starts to think, these people (managed care) tell me treatment should be over, why is it not over."

Therapist D described a client who was discharged from the hospital with full-blown OCD and chronic alcoholism whose care was approved for six sessions. Therapist D felt he needed a number of years of therapy for a successful outcome. He added,

"This ridiculous expectation is set up, like you are supposed to managed the crisis and discharge him. Now, you have an entire industry telling everyone that people have been getting way more treatment than they need. There should be shorter-term interventions. You have got a whole industry built up on the idea that treatment should not take that long. Patients come in and they want to be out in three sessions. It is looking for instant gratification."

This issue was closer to heart for this therapist than the others interviewed.

Because of his analytic orientation, Therapist D framed patient investment issues to reflect a psychodynamic form of resistance. He said, "Before managed care really had a stranglehold, there was always resistance to treatment. It takes time. It is relatively painful if you are going to get into the things you need to. It costs money. Now, a lot of it will be manifested in terms of well they did not feel like taking up the fight with the insurance companies so they would stop treatment."

This new resistance stemmed from the claims from managed care companies that treatment be shorter or quicker. Therapist D added,

“It facilitated a lot of resistance to getting deeper into treatment. This provides yet another impediment for the resistance to join. If you are ambivalent about treatment and you are getting a very strong message that long-term treatment is not necessary, and they are only financially going to support short-term therapy, it may be enough of a force to have you leave early.”

The paramount concern, for the patient who has managed care, was a perceived decrease in the quality or effectiveness of care. Issues concerning quality of care took a number of forms, from delays in or interruptions of treatment to negative outcomes for client well-being. Therapist B spoke about treatment delays caused by the slowness in the authorization and appeals procedures. She said, “If they deny a claim, then it works its way up to the next level. This could take weeks, months to have a decisions made. Sometimes the appeals can take forever.” This concern was similar for Therapist D who said, “The other thing is the interruption of service, constantly being told that treatment would have to stop unless information was provided. Intrusion in the process again.”

The quality of care issue specifically concerns the disruption, denial or lack of services available to patients in need of initial therapy or therapy beyond what managed care will certify. Therapist C said, “It is cutting down on the cost of healthcare. Do I look upon that as positive? No. Society may; certain segments of society. We might be saving but it may be that we are saving because there are less services available. It is rationed care. That is what we have.”

The following story relates Therapist C's concerns. Hospitalization was denied for a man expressing passive suicidal intent by neglected advanced diabetes; he already had toes amputated. His wife recently left him because of stroke-related personality and mood

changes. He had become tearful, depressed and somewhat explosive about his physical disabilities." Therapist C wanted him briefly hospitalized to assess suicidality. He said, "They turned him down after, I think, three days. They were not convinced he was going to hurt his wife or himself. It was not severe enough."

Therapist C related another inpatient hospitalization denial of care involving a psychotically depressed woman who was in the middle of her second course of shock treatments but managed care "did not allow her stay. She was hearing voices and had an urge to jump out the window. They felt it was borderline. They said she did not need to be in the hospital. We did ECT anyway. They felt she was much better because she was interacting. They were not sure that she was serious about jumping out of the window."

Therapist A was also forthcoming with examples of treatment failures resulting from managed care interference. The following anecdote describes his belief that managed care panel therapists offer lesser quality care because they alter their therapy approaches to save time and money. He had a patient who became very depressed following a diagnosis of breast cancer and the death of her mother. She saw a "managed care psychiatrist" briefly whose therapy sessions were only a few minutes long because the psychiatrist believed she had an HMO insurance that restricted fees. In fact, the patient had a PPO plan and, when the psychiatrist became aware of it, began to offer her longer therapy sessions because of the expectation that full fees would be paid. Angered by this, the patient and left the therapy to see Therapist A.

Therapist A contextualized the poor care this patient received in terms of the actions of the therapist. He said, "I will tell you what I do know. She was being seen, even when she was getting more depressed, on average by the clock, between eight and

14 minutes per visit. He was not taking her seriously. He was trying to make the right diagnosis, medicate her, and get her out of his office.”

These immediate negative effects of care denials were supplemented by similar concerns about the long-term effects of inpatient and outpatient care denials. Therapist A felt that “overall dollars and cents, it is going to cost them more money not paying attention to these things. An ounce of prevention truly is worth a pound of cure.” Without the insight and behavior changes that accompany it, “it will come out in a different way.” Therapist C also felt that patients are adversely effected in the long run. He said, This is managed cost. It is not managed care. You have to go to doctors. If you have a kidney stone, you have to go.” He felt mental health concerns should be treated as seriously.

The above alludes to the medical offset effect; care or prevention, of mental health issues, in the short-term, will save on general health care expenses in the long run and result in greater work productivity. Therapist A returned to this topic when he said, “It is going to wind up costing any health care provider less money because if they are emotionally healthy, they will be physically healthier. That has been proven. A happier patient is a healthier patient. It will cost them less dollars under the surgeon’s knife or in the medical office.” Therapist A considered the mind-body issue to be an important and neglected facet of human health when care decisions and policies are made.

Therapist C also touched upon this issue when he talked about the uselessness of categorizing people as a basis for making authorization decisions about psychotherapy. He said,

“Yes you are sleeping better. Yes your appetite has improved. So you cannot get anymore treatment. I can’t see the doctor but I still have not reconciled the absence of my father through the years. I do not know where I am going. I feel

unfulfilled. Managed care does not want to know about that. They want to know from decreased sleep, decreased appetite over the week.”

The effects of restricting care and focusing only on symptom reduction as indicators of psychological health creates a situation of incomplete care for the patient.

It was consistent across the interviewees that, although they believed patients did not receive a level of quality care that resulted in completed therapies, most interviewees did not believe that managed care rules or policies resulted in patients returning for treatment more frequently because issues resurfaced. Though an apparent contradiction, the issue is one of recidivism versus problem rectification. Like Therapist B said, “Yeah they come back but they come back anyway. People do that; they take breaks. Because it is short-term, they are not there for the long haul.” Therapist A said, “I do not know if they come back. I do not think they get cured as well. I do not think they get healed as well. Given enough pressure, we all decompensate unless you help somebody develop better tools to deal with pressure so they are not always prone.”

Therapist D agrees that managed care involvement has not effected the rate at which clients return for additional care if it has been completed or cut-off. He said, “I have patients who come back from time to time but not related to whether it was stopped prematurely through the insurance.” For Therapist D, what has changed is that managed care restrictions have contributed to client’s resistance to treatment; managed care has become a, modern-day source of resistance to going deeper into and continuing therapy.

There was agreement that patients are negatively effected by managed care’s intrusiveness and the interruptions in care resulting form restrictions to save money. Therapist A saw the issue in terms of the distractions for and pressures on the therapist

and said, "We are all negatively effected. I do not thing they really get what they could; that they have the undivided attention of the person that is in front of them. The quality the patient receives declines; absolutely. You are distracted because of the pressures."

Therapist A continued his reflections on the quality of care provided by therapists with managed care. He said, "They are really not dealing with healers. They are dealing with business people who are trying in a business fashion to provide some healing. It is not a bargain if what you are getting on the other end is somebody that has to sandwich in as many people as they can to make a living. It is a lesser quality. I am hard pressed to look at it a beneficial what other people are providing. There is no real help."

Therapist A further addressed this issue of the decline in quality of care resulting from the changes in the mentality of the therapists who take managed care. He often refers managed care patients to in-network providers because he does not want to deal with managed care, "I send them out. I send them shopping. A lot of the patients will come back and pay my fee because there is nobody home where they are going. It is exactly what they were told it was going to be in terms of managed care." Therapist B believes "lots of people who I do not think are good therapists work for managed care; people that I would not go to for therapy. I think what people are finding is that I did my in-network person and they were terrible. I spent all of this time and I did not get help."

Therapist E believes experienced clinicians are exiting the managed care system; patients, in turn, are following and will pay more out of pocket for better care. She added,

"The best and experienced clinicians are not available within managed care networks and therefore, people in those networks are not getting the best clinical service they could. I think there are lots of docs in the managed care companies that are not very good. They do not really evaluate these patients. And that could be an ethical dilemma in and of itself. I think people stay in because they are new,

they are trying to build up a practice, get referrals. People who can't make a living stay in too; that to me is indicative of people who are not so hot."

Therapist A believes therapists stay with managed care out of a fear of losing clients. He said, "I think most of them are afraid not to provide for the managed care companies.

There has always been that fear that if they do not take those patients Dr. Patel will, or Dr. Smith. They're all afraid to lose what they have. I think they are fear motivated."

Like Therapist A who related quality of care to medical offset effects, Therapist B also focused on the financial causes of the declining quality of care. She said, "It is all so driven by cost. I think that definitely effects people's treatment and in the end you end up paying more than you have to. Really so much is driven by how can we get this person out of treatment fast rather than how can we supply the best thing for the person."

Therapist C also spoke about poorer patient outcome in terms of happiness and level of functioning. He said, "The striving for a certain level of improvement may have to be by the patient alone. If not, they come back and go through another series of certified visits at some future time. To the extent that cost on some level reflected quality, you have to question the quality. They would say there was a lot of unnecessary, unethical treatments going on and now they have cast a much tighter reign. But, I think quality of care has suffered. They do not get the full spectrum of care that they could."

Therapist D sees the decline in the quality of care as stemming from a different aspect of managed care's involvement: the interruption of service or the denial of care causes patients to quit therapy prematurely either for financial reasons or because the managed care dictates have encouraged their resistance. He provides a cogent analogy:

"I would probably say that there are less people returning who stopped because it was probably a less satisfying experience. I have had people come for a year and

stop but it was a productive year. It was sort of mutual. The six to ten sessions, it is so artificial; it is not an ending that occurs because some issue has been worked through. It is based on an external and arbitrary time limit. It would be like saying, if you are supposed to take an antibiotic for 15 days and instead the insurance company only pays for ten days, then you are going to have a lot of people who are stopping it prematurely. I do not think the quality of the antibiotic is compromised but the effectiveness of it is going to be diminished."

This therapist makes an important distinction about the changes instigated by managed care: it is not so much the quality of care provided but the effectiveness that diminishes when managed care constrains the amount of therapy provided. Without sufficient time to properly deal with problems, the effectiveness of even good therapy declines.

Therapist E held similar beliefs related to the premature termination of treatment. She said, "I think that people are getting compromised care because care is cut off before it is appropriate." For Therapist F, the time factor was relevant as well. She said,

"If I have this person now going out-of-network, certified for a year, I have time to work with this client. The people that you get really limited with, it is a Band-Aid. I do not feel comfortable within myself that their changes are good and permanent changes. I see people coming out of the hospital sicker. Shorter hospital stays. People being medicated and not being closely monitored I disagree with the way they have tried to economize."

One other quality of care issue emerged that was not directly related to patient care and concerns training institutions, the techniques future therapists are being taught, and the availability of the supervisors doing the teaching. The issue involves the mentor's ability to provide training and supervision to people in a managed care atmosphere; whether because they are constrained by their own practices or the new policies of the institutions they represent. Therapist A, reflecting on his training experiences, said,

"We had academic institutions where the academicians did not have to justify their position by seeing a number of patients in a clinic. They were available for incredible amounts of time. They are being taught how to provide psychiatric services in a managed care environment. I had supervision when I was learning to

do therapy. Someone who I could really sit down with and who spent the time. It is not available. A lot of the transactional stuff that you need to learn has to take place in supervision. It is called analyzing the transference. I think you are being short-changed. So is every future patient you are going to have.”

Therapist C saw similar effects for those in training and for recent graduates. He said, “The younger guys, you get out, you need a job are more likely to dance to their tune or rather be trained to do so. It is not like you have an established patient base. They will learn, certainly they will get more training in brief, focused, time-limited psychotherapy.”

It was telling that these very issues were what led Therapist D to re-enter training as a psychoanalyst. For him, interactions with colleagues used to be times for educational discourse about readings or patients. He said,

“Every time I would see a colleague, five years ago, all we talked about was managed care. And I thought to myself, I cannot take it anymore. So, I enrolled in an institute. Total focus on clinical issues. They were not bred on third party reimbursements and so there is not the attitude of the necessity of third party reimbursements. It was like it used to be in graduate school and in early training where the interest was on patients and patient care.”

Though training issues did not emerge as an independent theme, they were perceived as relevant to the current status of quality of care through the person of the therapist. Many of the interviewees agreed that the new focus on short-term care, precipitated by managed care, will effect the trainees as well as the people serviced by them.

Theme 6: Responses to Managed Care: Manipulate or Avoid The System

Each of the interviewees had attempted to manipulate or beat the managed care system and, when that proved to be too much of a task, chose to exit the managed care system altogether. One way therapists attempted to beat managed care concerned the diagnostic categories used to justify and obtain treatment authorizations. This meant the

use of diagnostic categories that each knew would enable ongoing therapy while avoiding those managed care will not certify.

Therapist A used diagnostic categories that “they will accept, psychosis, affect disorder, a major affect disorder, behavioral problems. The unhealthier the label, the easier it is to justify it. It is easier to rationalize.” Therapist B added, “I have to write down a diagnosis where they are able to receive therapy. You present it in a format managed care will accept.” Therapist E spoke about carefully choosing diagnostic categories that are “going to get me the maximum number of sessions for someone who needed them. A lot of my adult referrals tend to have clear Axis I diagnoses, so it was easy to document the need for treatment.”

These therapists spoke about which diagnostic categories were not acceptable ones for managed care treatment authorization. Therapist A said healthier patients with the following problems would be hard-pressed to authorize:

“Situational problems, marital discord, family disturbances, couples issues, the patient that is not floridly depressed but has had a smoldering depression for a very long time. There are DSM codes for the marital problems or the parent-child problems, the family problems. They come complete with depression, anxiety, things that are covered. But these are not covered by these companies.”

Therapist B handled this issue the same way She said,

“If you think you will need to work with them for a long time, you cannot give an adjustment disorder diagnosis that only allows you to work with them for six months. You have to give them something else that will allow you to work with them longer; or be briefer. I almost never give somebody a personality disorder diagnosis because things could take a while and that could set us back.”

The interviewees had learned that certain diagnostic categories were easily certified by managed care and provided clinical information that fit these criteria.

Attempts to beat the managed care system were frequent and varied. Therapist B called them "obstacles that we have all learned ways around." When Therapist A knows he will refer a clients with managed care to an in-network provider, he advises them on how to maximize their chances to receives enough therapy. He said, "This may be what I consider to be the biggest problems you need to work on. However, if this is the problem that you present with, they are going to cover it. I will explain to them what they are going to need in their complaints in order to be able to get it covered."

Therapist B admits choosing diagnostic categories to benefit the client . She said,

"You have to go around the system to get what you need. Sometimes, phrase things in a different way. You have to learn to work the system. How to get more sessions for clients. It is a good skill to have with a managed care company; learn how to give a diagnosis in a certain way."

Therapist B says "there is no questions" that therapists are just writing "what they know managed care wants and needs to hear." Therapist C agreed. He said, "The way to do it is you do not dictate things that would be problematic. Like some firms keep two sets of books. I am partly detaining, thinking, how will they respond if they review it." Like him, Therapist F said, "I know people who are working the system and abusing it still. The people have just learned the system."

The most creative and vocal of the interviewees, in terms of this theme, was Therapist E. First, insurance companies would only pay for a one session evaluation but this therapist felt a thorough, two sessions evaluation was necessary. Therefore,

"I would simply bill it as two different days. I found ways around the rules basically; ways to beat the system. I knew what they needed to hear. I knew what kind of treatment to list. I was able to medicalize the treatment plans in a sense. I found that, if you sent them a good one in the beginning and looked like you knew what you were doing, they did not really pay too awfully much attention to the follow-up one. I never said what the real problem was."

Therapist E continued to talk about how she manipulated the managed care companies to obtain further care for patient she felt needed it. She said,

“I just navigated it. I have no compunction about it at all; it does not feel ethically wrong to me. I never got paid for something I did not do but I worked it around so that most of the time I got paid. We were going to get whatever we could get out of managed care and still do it legally. You knew after a while where you could not take it. I manipulated them, right, you got it. Sometimes I would say, we have got to get some more sessions here. I may have to make it as bad as we can so that we have a ways to go. As far as I am concerned, the end justifies the means.”

The way Therapist C got around the system was similar to Therapist E focus on monitoring the rate of progress presented on managed care paperwork: he would carefully chart the negatives so as to continue to get care approval. He said,

“What has to appear in the charts is a little bit like congress in session. When you see congress in session, you do not really know what is going. All of the stuff goes on behind closed doors. The chart always has to appear more severe than it is. You have to chart the negatives. You should not chart the positives.”

Therapist D did not take this route to manipulate managed care; instead, he would be up-front with his patients but remind them of the need to present issues in a certain way. He said, “I would say to the patient, this is the form that the insurance company sent, what would you be comfortable having them have on record, understanding that if you make it look like there is no problem chances are they will not support treatment.”

Therapist F related the story of a patient who had recently been to her psychiatrist and looked at his notes. The psychiatrist had indicated that she was suicidal and “she was not. The person says, that is for the insurance; justifies it at that.” Although therapists perceived the need to present patient problems and progress in a certain way, there was the dilemma or ethical conflict of presenting things that may not completely reflect reality even though care approval is dependent on it.

For those therapists who remained with managed care, the manipulations of the system were accompanied by a self-declared acting out. Therapist E gave an example. She would leave informative pamphlets out about insurance so that patients would be knowledgeable about where their personal information ended up. She added, "I sort of act out in this way. I felt like I was going to be in this but not of it; I would do the managed care thing but I would guard my patient's rights. Initially, I needed referrals. I did not want to be too openly rebellious. The other thing I did which was sort of passive-aggressive, my hand-writing is horrible and I did not make any effort to improve it."

Keeping progress notes private at all costs was discussed by Therapist F who said, "I have always had a private practice model. They would have no idea what these notes were about. I write snatches of conversation, vague notes. I will put something important like denied suicidal or homicidal ideation. But the content are really sort of vague and could not damage anyone if they were known." The goals of these manipulations are to help clients get care approvals and to maintain a patient's confidentiality and privacy.

The second avenue that therapists chose in response to their concerns about managed care was to avoid that system completely. Each interviewee had tried to work within the system, openly and then by manipulating it to obtain the financial backing their patient's needed. When this did not work, they abandoned the system completely. The reasons were many but the negative descriptors given by the interviewees make it more than apparent that it is not a system with which they are comfortable or happy.

For Therapist F, it was the problems associated with authorization regulations and the idea that managed care appeared like a financially abusive system in its own right. She said, "All of this stuff, I find very cumbersome. Tiring and cumbersome. I think it is

a big rip-off." Both Therapist's E and D felt that managed care left no option but to act manipulatively. Therapist E said, "I sort of noted my own feeling that this was not a concept that I really ethically agreed with."

Therapist D said working with managed care a negative experience. He referred to it as "obstructive, intrusive, coercive, deceptive. I think the deception is another of the big things." He was referring to managed care advertising benefits, 20 or more sessions, that clients could not use because "After three sessions, I get a letter, you need certification. It looks very easy up front. After the initial sessions, then comes all of the paperwork and all of the disclosure in order to get further care. Yeah they have 50 sessions in theory; they have to be psychotic to get it."

Therapist A focused on the "disrespect" he felt as a professional. He said, "I think the whole system is wacked. It is disrespectful to me going into this field, to anyone in this field; disrespectful to human beings. It is disrespectful." Therapist B had worked within the managed care system but said, "Now that I have seen it from the inside, I think it is horrible. I guess I do not have a lot of good feeling about them." Finally, Therapist C's negative feelings focused on the farce he perceived managed care to be. He said, "It is very demonic. It is a charade. It causes resentment that we are doing it; that we have to do it. It is demoralizing. It is the need to go through a charade. It is terrible."

The avoidance stems from the cumbersome nature of the managed care authorizations and paperwork, the reductions in financial reimbursement, beliefs about proper clinical care, and the ethics of violating patient confidentiality and privacy. Therapist A stated, "I try to avoid them at all costs because it takes so much of my time, it is not worth it. I want to provide the service that I provide. I made a promise that I would

always work doing what I wanted to do as best I could, and make a good living at it. So I will not do managed care. The whole concept led me to leave that system."

One reason to avoid managed care is the therapist's desire to work the way they believe is most clinically indicated. Therapist B concurred, adding, "I do not want to do it [*authorizations and paperwork.*] I just want to do the clinical work." She went on to talk about how unhappy she was when she worked for managed care: "I felt that I needed to be loyal to it while I was there. I probably should not have been there ever. It was really not the right job for me. It did not quite fit with my values. I just knew that I should not be there any longer than I needed to be. So when I could leave, I did."

Therapist C was more specific about the reasons he tries to avoid working with managed care. He said, "I do not have that many managed care patients. I have dropped out of a bunch of them. I would rather spend less time seeing patients than having a bigger practice with only managed care. It is the paperwork and the pay. The payments are just awful. That they [*managed care*] are fraudulent is ignored. It is not worth it. It is not meant for me to do it so I dropped out." For this therapist, rather than deal with all of the perceived problems, "I opted to try to do without. It has worked for me."

Therapist D spoke similarly. He said, "I got on all of the panels I could get on initially. Most of them stunk and within a year or two, I started dropping out of them figuring I would rather not do the work. It was an absolute nightmare. I would rather have no patients than deal with that s____. I want to deal with patients. The violation of privacy is probably the main thing. It is not necessarily the work burden but the work burden and the coercion to violate privacy. I am so sick of it." He also cited a perceived failure of support by APA and NJPA as reasons he stopped fighting back and left the system:

"I felt totally unsupported and left out to flap in the breeze. APA and NJPA, their whole mindset was get on every managed care panel you can get on and sort of hedge your bet; we do not know where managed care is going but it is a force to be reckoned with. So get on all of the panels and do not be closed out because you will lose your practice. I thought we were misled. I thought if we acted as a unified body, if APA and NJPA told everybody, sign up for none and we will act as a unified front, I thought we'd have been much better off."

Therapist F also expressed this concern that providers and associations are not sticking together yet to confront managed care.

Therapist E stopped working with managed care for similar reasons. She said, "I got aggravated with the whole thing. I got tired of being paid miserably. My husband lost his job. I had to make a living and so I did it because I needed to. So it is with great trepidation that I got out of managed care. The whole spirit of the thing, I did not agree with.." She elaborated on the financial reasons to abandon managed care system, adding,

"I do not think professionals who are good and experienced are willing to work for 57 dollars an hour and be told what to do by someone that they have far more experience than and they do not want to work for no money. The decisions are not clinically indicated. The pendulum has swung too far and I am just personally glad to be rid of all that."

Therapist F's issues of contention were similar. She said, "I have gotten to the point where I am a totally out-of-network provider. I would never pursue being an in-network provider. Probably more than anything else, because of myself, the paperwork and the cumbersomeness of it. Money was, because when you are taking two or three, you have a patient hour and then you have another hour or two hours struggling on the phone with people, developing treatment plans. Doing all of that."

One way to avoid managed care is to refer patients with it to an in-network therapist. Therapist C said, "I will maybe refer them elsewhere but I will not do it;" deal with managed care restraints on his clinical decisions." Therapist A concurred. He said,

"A lot of them wind up being referred by me into their network because for 15 dollars, they might be able to get the care they need but it will not be in this office. I do not provide managed care. You can go through the list of who your providers are and I will try to find you someone that, beyond your first visit, will not have you in and out in 15 minutes trying to throw medication at the problem."

These interviewees, in turn, prefer to fill their treatment schedule with a non-managed care clientele or take on patients as an out-of-network provider. Therapist B said, "Then you end up having to fill your practice with people who are not in managed care, who do not use managed care to pay for it. And in some ways that is better. But you are forced to find a different population to serve." She adds, however, "I would much rather, I mean I have patients that I see at very reduced fees but that is my choice."

These therapists spoke about feeling a lot happier and more relaxed having decided to stop working with managed care. Most of the interviewees negotiate fees with clients to make it financially feasible to continue without managed care involvement. Many patients chose to bypass using managed care and were happier for it themselves. This was particularly true for Therapist D who said,

"I just started saying to patients, we can either deal with this every five sessions or negotiate a fee and go outside the network. I would tell them, in the first session, you may have difficulty getting your benefit; that may be a factor in treatment. They may want you to be here shorter than I think is necessary. We may need to talk about negotiating a fee. A lot of patients went out of the network."

Therapist D related this decision to leave managed to his psychoanalytic and psychodynamic focus. He said, "I am interested in long-term work and I understand that it is not always supported by insurance companies. If the insurance company withdraws support, we will work together to come up with a mutually agreeable fee. An insurance company can say this is a ten session case but that does not mean I have to accept it."

These therapists are more comfortable without managed care because they can devote more time to clinical work and endeavors. Therapist D said, "It is purer clinical work, like it was before managed care really got a stranglehold on treatment. That is why I got out of most of the plans. I was doing the kind of work I wanted and I am 50 times better for it. If I do not deal with managed care, all we talk about is what the patient brings up and what's on their mind; the way it should be. The patients I was working with felt better about the work."

Like Therapist D, many of Therapist F's clients did not want to sacrifice their confidentiality or their privacy and prefer to bypass the insurer. She said, "I do see people who are purely cash people who have serious and persistent mental illness. I do not do insurance with them primarily because they do not want this stuff known. I actually would take lower fees to justify not using insurance." Interviewees abandoned working with managed care systems because of money, time available for clinical work, threats to ethical mandates, and concerns about client well-being. Each appears to be happier for that decision. Each would rather lose some income but retain control over treatment decisions they believe is most helpful to clients and with which they are most satisfied.

Theme 7: Changing the Health Care Insurance System

Thoughts abounded from these interviews about changes to make health care insurance systems more workable and satisfying for all parties. Before discussing them, it is worth mentioning the fewer positive changes these interviewees believe came from managed care that should not be altered. Though few in number, laudable aspects were

addressed. First, the interviewees believe managed care has staved off financial abuses by professionals who previously were not held accountable for fraudulent practices.

Therapist A stated, "I think there have been a lot of abuses in the system. We did not police ourselves well enough and there needed to be an adjustment. There was a lot of milking the system." Similar concerns existed for Therapist C who stated, "There probably have been incidents, percentages of egregious abuse by the physicians but I do not know what the percentages are." For Therapist B, her initial hopefulness about the managed care system centered around its potential to "weed out a lot of stuff." Therapist D was perhaps most vocal and descriptive about this perceived origin of managed care. He said, "There was this attitude of the doctors being greedy and unethical and pumping these sick patients, keeping them in treatment when they did not want to be or need to be; the mentality that the doctors were taking advantage of people for their own gain."

The interviewees focused on abuses by physicians or psychiatrists only. Therapist F spoke fervently about this issue. She said, "I think that one of the problems was the fee-for-service type of things that physicians do. I think these people are totally out of touch with reality in terms of how they value themselves financially, and their services." Therapist F, however, voiced an opinion held by other interviewees; managed care organizations have shifted the abuses of the system from physicians to themselves.

A second positive outcome of managed care concerned treatment accessibility; managed care has opened up treatment, at least initially, for insured individuals because, as Therapist B remarked, "sometimes people do not have to pay very much out of pocket." For this therapist, the system has led needing individuals into treatment before

problems develop into full-blown crises: "I think people maybe do not wait as long to get into treatment; people will come when their problems are not so out of control yet."

The same opinion was voiced by Therapist E was said, "It seems like maybe there are more people getting into treatment today." Along with Therapist D, she believed managed care helped to educate individuals about the therapy process. The consensus was that, because of the small co-payments, people were in a better financial position to seek out care when they needed it. Also the consensus, these interviewees felt that only initial treatment was more available; because of other managed care generated problems resulting in shorter treatment lengths, therapy patients were not increasing their time in what they consider full treatment that ends when issues are successfully resolved.

Therapist B, the only interviewee to have worked for a managed care company and to have an insider's view of that system, raised an interesting thought about another positive result of managed care: it has helped potential clients feel more re-assured about the therapist who treats them because managed care follows procedures to ensure the proper credentialing of therapists on their panels. She said, "Each company does their own credentialing which means that they make sure that there are no malpractice suits against the clinician, make sure that your license is up to date." Managed care provides a check-and-balance against charlatans providing psychotherapy.

Therapist C felt that managed care, in general, has done some good in the areas of preventive medicine of medical issues and problems. Therapist C said, "The introduction of prophylactic measures of health care. It might increase inoculations and increase the awareness." Like other interviewees, Therapist C's believed that, unfortunately, this

mentality does not exist in mental health where "It is unlikely they will say, Look you are feeling down, speak to your therapist for six sessions so you can prevent twelve later on."

Two interesting, somewhat facetious, thoughts about positive results of managed care came from Therapist's C and F. Therapist C discussed the issue of malingerers. In his opinion, managed care restrictions with care length have helped him discharge malingerers from inpatient hospital units because it provides an opportunity to limit-set and motivate patients to establish and reach goals." Second, Therapist F thought managed care has helped lower the unemployment rate by "employing a lot of people as case reviewers and a whole new category of people in hospitals who are review people."

The therapists here interviewed did acknowledge the positive aspects of using DSM-IV nomenclature to assist with focusing treatment plans. Therapist C said,

"Maybe there is some argument that it leads to a greater conceptualization of their problems because you have to define it more specifically; the problems, the goal, and the treatment. That is one of the contributions of the DSM. Before the DSM, people had their own criteria. It has become more empirical, more quantifiable, more open to whether things worked. It helps because really when you are treating somebody, you should have in mind what you are treating."

As a result, clinicians have taken a closer look at their techniques and approaches, hopefully using more diagnosis-appropriate techniques.

Therapist E said, "It has pushed clinicians to really take a look at what they do in each session and try to be a little more efficient in helping people. I think it has shifted therapy to a more focused, patient-centered treatment. It has made us look and do things a little more thoughtfully. I think that has been good. I think there has been an impetus to get more specific training at techniques; to be more specialized in terms of tailoring treatment to patient diagnosis than it was before."

These thoughts about positive changes notwithstanding, the final theme to emerge from these interviewees centered on the numerous and spontaneous changes these psychotherapists think are needed in the health care system in order to make the behavioral health component more agreeable for patients, practitioners, employers, and insurance companies. Therapist A viewed the current system as dysfunctional. He said,

"I do not think we are practicing as well as we used to; as well as we could. I do not think medicine has ever been better on the face of this earth than it was here before managed care. Our system was where everybody wanted to be. You could be independent. You could have respect. It is not that way anymore. The whole system is a hard place for everybody to be. There are still things to recommend it because you are helping people. But we do not get the same respect we used to."

Therapist C continued this thought. He said,

"We have destroyed our system. It is really a mess. All of the politicians that speak against managed care, not so long ago that they were pushing it. People wanted it. If society has decided that we can't afford the cost of health care, that we would rather increase our defense budget, that is what this is accomplishing."

There is agreement that the past fee-for service system was no longer doable or useful but that managed care, as it exists, is not functioning well. Modifying the system was a pressing theme for Therapist A. Therapist A said, "I do not think they should exist at all unless they are modified completely. They do not serve the patient in any way, shape, manner, or form. Yes things have to be cost-effective but managed care is not useful to anyone. I think it is really a very pivotal issue." Therapist C added, "I do not have the resolutions. Societal movements, like pendulums, they swing. That could take many, many years and it probably will. This is here; it is real. Unfortunately."

There was consensus that, to make psychotherapy function more effectively, one of the changes needed to involve making the financial investment higher for the patient. Therapists recognize the need for and value of patients making a financial investment in

their own mental health care so that they also make the psychological investment to get well. By implication, one proposed change involves a higher co-payment for therapy. Interviewees believe this could rectify this negative implication to the therapy process as well as the financial problems leading therapists to abandon managed care systems.

Therapist A was vocal about this issue. He said,

“There has to be a much higher co-pay so that there is more of an investment in the process so people will get well, not just coming and complaining. In psychotherapy, there needs to be a higher co-pay. If you want the help, you have to invest yourself in the help. And part of that should be underwritten by the patient themselves. If they want emotional help, let them pay for part of it. There should be something that the person has invested before you relieve them of the burden so that they will work. The object is to get them to work.”

Therapist E offered her own version of changing in the financial arrangements for psychotherapy. She said, “People ought to be paying a little more than ten dollars a session. They ought to be paying something meaningful so that they come in and use the work. I think everybody would make out better.” She gave the following example for a social worker receiving 80 dollars per session. She added,

“The patient paid forty and the insurance company paid forty so that the patient would be paying more, the clinician would be getting more and it would be more meaningful than ten dollars a session. If people are paying for something, they are invested in it. That’s why you don’t see anybody for free. There is something about taking responsibility for your part of the relationship and bringing something to the table and valuing the interaction, valuing the treatment.”

Therapist D addressed this issue when he talked about using long-term, psychoanalytically based treatments with clients; therapy where clients take fuller responsibility for their care. He said, “Ironically, I find the more and more committed I am to working this way, the more attractive it is to patients to take responsibility for payment in whatever form it takes because, without it, there is not the serious investment

in the treatment. Managed care totally takes it out of their hands. They come in and flip you ten bucks and then they leave. To me, that makes it a less serious proposition.”

Clients who are more responsible for their therapy will find it more meaningful to them. The therapist becomes more invested as well because they feel they are providing useful care. Therapist D continued,

“When they know the money that is being spent, when they are not relying on the doctor to provide everything, I think it is a much healthier dynamic. I think it is infantilizing if someone just shows up and has no responsibility beyond that point. Someone is supporting the treatment; it should be them. I do not think it is the money per se. It is the having no responsibility beyond the money that is more insidious. I am more interested in their sharing the work and taking responsibility. As a totally independent factor, if you are only paying ten bucks versus 50, I think it does effect their valuation of the services.”

The idea of eliminating the entire managed care system also came up. Therapist B said, “I would rather pay the clinician than the managed care company.” These therapists saw problems with the amounts of patient care dollars that managed care companies used for their own expenses and financial advancement. Therapist C added, “The costs of managing are very expensive. I am not sure it saves money. They reshuffle the money. Most of the money is going to the executives. They are hiring a lot of people to do the work also. It gets lopped off of the money that was going to actual health care.”

Inherent in these ideas is a better reimbursement system for the provider of mental health care; one that does not lead to compromised care, care cut short because of capitated rates. Therapist F also spoke about the money being pocketed by managed care executives as a new turn on the abuses that managed care was designed to prevent. She highlighted the exorbitant salaries of MD professionals in the mental health field as something that would need to be changed. She felt that many of the abuses in mental

health originated with this discipline. Her solution would be gradated but more equal payment to the various professionals who conducted psychotherapy. She said,

“Look real hard at physician’s salaries as opposed to psychologists, as opposed to, and kind of work on equalizing things. Not equalizing necessarily; there always has to be a boat captain. I cannot see the physician’s salary being five times greater than another professional’s salary who was providing similar services. You need some people with integrity to be involved at the top and throughout the system. There needs to be a resurgence of ethical values.

Interviewees generally felt that the financial allotments or reimbursement rates for professionals needed to be increased. Many therapists cannot financially function with the income cuts they have faced with managed care. The proposal of a flat, annual amount was prominent. Therapist F felt this would eliminate the need for managing care.

Therapist D’s proposal is, “Just have a flat amount that they are willing to pay for the year, three thousand a year whatever the amount is, and then you and the patient work it out; without having to disclose information, without having to make these arbitrary treatment decisions that they make. It puts it back on out lap; the patient and I work it out. You know what you are dealing with.” Therapist D continued that corporations need to more closely look at the history of behavioral health care costs:

“Some patients are only going to come in once anyway. I think the fear is, if you had 10,000 dollars allotted, every patient would use up 10,000 dollars worth and they would go broke. You read Freud’s work and there were people who were dropping out after two sessions. It is an inherently painful process; it is not like people flock to it like they are going to the movies. There are only a minority of patients who are going to stick around to do the long-term work.”

Therapist E proposed a similar flat annual rate that was a compromise between managed care and the traditional fee-for-service plans. She was concerned about the uninsured being unable to access mental health care. In her proposed system, health care could be available to all persons. She said,

"I am wondering if there could a closer product between a totally managed 10 or 15 dollars a session to the converse would be the whole indemnity program. If there were some product where they reimbursed clinicians a little bit more and patients picked up a little bit more, you could have 25 sessions a year at a 50-50 rate and have clinicians accept less money to get those referrals. It could give you a good six months of intensive treatment. If people needed or wanted more, they would pay more. I think 25 sessions is a reasonable amount to give people."

Therapist F was hopeful that a socialized health care system could rectify these problems. She said, "I am a great believer, although this is probably going to sound real crazy, in a totally nationalized health care system. I should say socialized system. I know there would be bureaucracy but you may be able to get more care to people, more of the care dollars into direct care. Socializing the whole deal would mean big, big change."

One of the ideas behind the proposal to provide a flat, annual amount of mental health care dollars is that treatment, like Therapist D said, would be back in the hands of the patient and therapist. Therapist B reflected on care decision-making in the past and said, "The therapy, the number of appointments, were usually set by the therapist and the patient. It wasn't driven by an insurance company. No one told you how many sessions you could have. You went until you both thought they did not have to come anymore."

Therapist D concurred with these thoughts. He said,

"The six to ten sessions, it is so artificial; it is not an ending that occurs because some issue has been worked through. It's based on an external and arbitrary time limit not the collaborative process that it should be. I'm not a surgeon; I don't render them unconscious, come in and do my treatment. It is fully participatory; Let me work that way and I am fine with it. If I were forced to, yeah, I would take a pay cut but let me still determine the treatment of the patient and stay out of it other than that. The patient and I will work out the rest; not some third party."

He, and all the interviewees, would rather have a flat annual rate with no managed care intrusiveness. They believe patient care decisions belong within the therapeutic dyad.

The financial concerns here expressed bring up the issue of mental health parity; the equality of mental health with other aspects of health care, in terms of financial compensation and benefits. This issue was at the forefront for Therapist E who said,

“I really believe that there ought to be more of this parity stuff with mental health because I don’t think we have mental illness, I think we have brain illnesses. Your brain is part of your body; it is not some separate thing. We are talking about depressions, unipolar and bipolar, as having a chemical basis; anxiety disorders do, eating disorders do, OCD does. We are made up of brains that direct our emotions, our feelings, everything. I actually think that there should be parity.”

A number of the proposed changes concerned legal issues. Therapist A brought up the first, related to the ERISA statute: holding managed care legally accountable for untoward care decisions. He said, “It used to be that doctors had to sign that they would hold the managed care company harmless in the case of a lawsuit, if they practiced bad medicine. Now, the HMO is on the hook too, as it should be since they are part of what’s going wrong.” Therapist C spoke about the difficulty suing managed care under ERISA. He said, “I would like to see them be able to sue. Why should they be exempt. They have taken advantage of so many things. They were, in the beginning, very arrogant.”

There was concern about therapists taking full responsibility for care whose determination was being made by a third party payer. Therapist D concurred, “You are still accepting all of the responsibility for care, all of the liability for care.” His concern about lawsuits extended to the issues of confidentiality, privacy and the request under managed care, to violate both. He said, “Some patients would rather have their doctor fill everything out. In ten years, when it turns up on a credit report saying major depression, then they go ape and want to sue me or something. So I think it is in everyone’s best interest for them to be in control of their own information.”

A legal area of interest to Therapist's C and D concerned review boards; internal and external organizations who manage appeals for care denials. Therapist C discussed how, with many managed care companies, he simply jumps to this part of the process because he expects care to be denied. He added, "In some states there has to be available an external review that is not beholden to the company" because review companies that are financially beholden to managed care can provide biased care decisions. He added, "The money ultimately comes from the insurance company." In his opinion, independent external review organizations, beholden to no insurance company, need to be established.

For Therapist D, the legal implications of working with managed care centered around the unethical and illegal aspects of violating confidentiality and privacy. He said,

"I can't tell you how many times I called up the companies and said, look, we have the New Jersey Peer Review Law which you are in absolute violation of. There is a prescribed process for disclosing information to third parties and, even with a patient's consent, you can only release very basic information...like identifying information and diagnosis, a qualitative statement about symptoms, a statement about prognosis. If they want to go beyond, they're supposed to contact the New Jersey board of psychologists who will get two peer reviewers but the insurance company does not get the information, they just get the decisions."

Therapist D says managed care companies claim to know nothing about this law and continue to request information from him. He further stated,

"So either they are lying to me just to try to pressure me or people are just giving them the information. Apparently a lot of people do not care about the law. I have a standard letter I send out now. I'm providing the information I'm allowed to. They say, if you don't provide the information, we'll refer them to another provider. They refuse to pay and we get into a big fight about it. I resent that they routinely, without regard for me or anyone else in the profession, demand that you violate the law. I just won't do it. I'd rather lose a patient than violate the law."

For this therapist, and the other interviewees in this study, ethical and legal implication of managed care regulations played a large role in his concerns about the insurance system.

CHAPTER V:

Summary, Implications, and Outcome

Distinguishing the Study from Prior Research

It is likely that some form of managed health care will be in existence far into the future. This was not debated by the interviewees in this analysis or questioned by those writers and researchers who study managed care. This empirical investigation sought to develop an in-depth understanding of the impact of managed care insurance on outpatient psychotherapy from the vantage point of the practitioners conducting that therapy. The goal of the analysis was an understanding of the relevant issues and processes that effect therapists conducting therapy within managed care systems; what issues or concerns exist and what aspects of the therapy process have been altered because of them.

Previous meta-analytic studies have measured psychotherapy's effectiveness and efficacy in terms of the psychotherapists, client, and treatment variables involved in the process (Clum, et. al., , 1993; Lipsey and Wilson, 1993;; Shadish, et. al., 1997; Shadish & Ragsdale, 1996; Wampold, et. al., 1997; Weisz, et. al., 1995). A number of studies have addressed the impact of psychotherapy in terms of the therapeutic factors or agents of change common across therapy types (Castonguay et. al., 1996; Goldfried, 1998; Granello and Witmer, 1997; Lambert and Bergen, 1994; and Weisz et.al., 1995).

These studies have relied on surveys or questionnaires that critics argue restrict answers to pre-established categories. Therein lies the root of the psychotherapy efficacy versus effectiveness debate (Kiesler, 2000; Persons and Silbershatz, 1998; Weisz, et. al., 1995; Wilson, 1995). In recent years, a wealth of literature has been directed at

establishing the efficacy of specific therapy approaches to specific problems (Chambless and Hollon, 1998; Crits-Christoph et. al., 1995; Kiesler, 2000; National Advisory Mental Health Council, 1998; Packard, 1995).

In response to this focus on EVT and EST, there is now a resurgence of studies and literature about the effectiveness of psychotherapy using global indices of change, functioning and well-being (Goldfried and Wolfe, 1998; Jacobson and Christensen, 1996; Lambert and Cattini-Thompson, 1996; Mintz et. al., 1998; Newman and Tejada, 1996; Packard, 1995; Pallak, 1995; Persons and Silberschatz, 1998; Schneider, 1999; Wilson, 1995). The studies are reactions against the compartmentalization of psychotherapy in efficacy research; effectiveness studies view psychotherapy as a whole process and sometimes analyzes variables less amenable to quantification (Seligman, 1995).

Much of the existing literature is an expression of professional and public opinion about negative changes and outcomes caused by managed care's role as a reimbursement and cost-containment system or highlights the ethical and legal concerns of professionals (Anders, 1996; Goldstein, 1999, October; Karon, 1995; Miller, 1996; Sleek, 1999, February). Opinion polls of consumer reactions exist as well (Farberman, 1999, February; Kaiser Family Foundation, 2000; Sleek, 1998, June). The APA is a vocal and prolific source of literature about the financial impact for the psychotherapist, managed care's impact in terms of legal and ethical concerns, and professional opinion about proposed changes to the health care insurance system (Foxhall, 1999, October; Newman, 1998, November; Rabasca, 1999, February; Rabasca, 2000, February; Sleek, 1998a, February).

The impact of managed care on the processes of psychotherapy, from the perspective of the psychotherapists conducting that care, has not received adequate

empirical attention. The impetus for this study arose from professional discussion, both within and outside the mental health disciplines, about problems from dealing with managed care that resulted in general rejection of this insurance system by professional communities. The questions in this study reflected a desire to understand the validity of the beliefs and concerns of the practitioners as well as what and how in the therapy process are being effected by managed care; if managed care was the negative influence professional opinion suggests, there was a need to address those issues with a data base to inform policy and constructive professional decision-making efforts by psychotherapists.

In one respect, this qualitative analysis extended the focus on psychotherapy effectiveness research, so as to direct future investigations; the effects on the process of psychotherapy, from the professional's perspective, were examined with interview techniques designed to understand individual perspectives and phenomenological experiences. The uncharted nature of this topic and the complexity of the therapy process directed analysis with qualitative methodology. Though sample sizes are much smaller in this type of analysis, the richness of the participant's answers and dialogue allows for a depth of understanding that can be lacking in quantitative approaches to empirical investigation; contextualized insight into the relevant changes, interactions, and concerns that have emerged since managed care began impacting the therapy process.

Qualitative analysis also facilitated the goal of this study because no standardized measures regarding managed care and psychotherapy have been developed to date. Previous research of psychotherapy process has not considered managed care insurance as a variable in its investigations. The themes herein developed provided understanding about which therapy processes have changed and in what direction that change has

occurred. Together with the research about variables that contribute to successful therapy outcome, including techniques, approaches, and client and therapist characteristics, the results of this study can inform psychotherapy research when managed care is a factor.

Study's Relation to Theory and Literature: Commonalities and Contrasts

The psychotherapists interviewed for this analysis were in agreement with authors who have addressed the origins of managed care; escalating mental health care costs, especially in the inpatient sector, and past egregious abuses by professionals precipitated the current managed care insurance systems (Anders, 1996; Frasier, 1996; Humphreys, 1996). Managed care has successfully tempered rising costs and encouraged therapists to develop and provide efficient, effective, and evidence-based treatments. These are positive effects for psychotherapy because they facilitate the development of more useful therapy techniques (Hayes, 1995; Persons and Silberschatz, 1998; Wilson, 1995) and training in them (Calhoun et. al., 1998; Crits-Christoph et. al., 1995; Davidson, 1998).

Hoyt and Budman (1996) suggest that practitioner's antagonisms toward managed care stem from strict allegiance to particular theoretical orientations and concern for their financial well-being; not for patient care. This analysis revealed that practitioners were concerned about the ultra-short therapies stipulated by managed care and their own inability to foster client insight in that time frame. The interviewees, however, represent diverse theoretical backgrounds; psychodynamic, psychoanalytic, family systems models and eclectic approaches that include cognitive and behavioral techniques. The data in this study did not suggest that adherence to theoretical orientation was a root of contempt for managed care; stronger concern existed about disruptions to necessary therapy processes.

Ethical issues emerged as a prominent theme in this analysis; interviewees were troubled by losses to patient confidentiality and privacy, triangulated/dual relationships, and the ethics of third parties dictating care for which the therapist was ultimately responsible. This is consistent with the existing literature that documents professional ethical concerns about managed care (Miller, 1996; Rothbaum et. al, 1998). APA (1998) found that 68% of therapists were concerned about ethical dilemmas created by managed care involvement in the treatment process. NJPA found that practitioners were concerned about managed care pressures to violate ethical codes of conduct (Rothbaum, et. al., 1998). Austad et. al. (1998) and Shore (1996) belief client freedom-of-choice and self-determination are restricted when length of therapy is determined by an outside agent.

Murphy et. al. (1998) found that 75% of therapists surveyed felt managed care utilization review procedures compromised client confidentiality. Moldawsky (1996) reported that professionals are confused about what disclosures constitute minimally necessary information for medical necessity criteria. Therapist D was most vocal about this issue. He had decided to adhere to the New Jersey Peer Review Law which stipulates that therapists can only disclose minimal client information to third parties. Therapist B wondered how well the disclosed information, doctored by therapists in an attempt to maintain privacy, really informs about the heart of the therapy process.

Bilinsky and Vernaglia (1998) documented therapist concerns about maintaining confidentiality when so many managed care employees have access to patient databases. Therapist's E and F were concerned that computerized databases render personal client information open to disinterested parties. Therapist D feared this left therapists open to future lawsuits because the information originated with them. He gave the example about

a managed care employee whose personal file was inadvertently viewed by hundreds of people during a presentation and who successfully sued for damages. Rabasca (1999, February) noted that managed care creates barriers to treatment because patients are reluctant to disclose sensitive information, in the therapy relationship, for care approvals.

The rules and regulations of managed care, requiring disclosure of client information, especially for care authorizations, is a cumbersome and distracting process that contributes to therapist unavailability and the desire to avoid working with managed care. This is also consistent with the literature. Karon (1995) noted therapist's tendencies to manipulate the system by using acceptable diagnostic categories and catch phrases; describing symptoms as more severe than they are in order to obtain care approval. According to Pipal (1995), psychotherapists are inclined to over-diagnose or create diagnoses where none exist, to facilitate third-party payment and care authorizations.

This emerged as a theme in this study. Therapists had developed ways to navigate the managed care system to obtain authorization of initial and continued care for clients: using benign, uninformative diagnostic categories or overly severe diagnoses, charting negatives or a slow progression of positive change. Many of the therapists in this study chose to inform clients about this documentation as a way to preserve the therapeutic relationship with their clients and avoid changes to the processes of their therapy.

Chodoff (1996) found that 86% of psychotherapists have reduced their fees in response to care denials from managed care; like the interviewees, some therapists chose to refer clients to other providers in response to those care denials. With client consent, most of the interviewees took a similar approach and opted either to completely avoid managed care reimbursement or work as an out-of-network provider; both approaches

included fee negotiation. Perhaps because these therapists began practicing before managed care rose to such a prominent role, they chose to exit the managed care systems. Part of that decision may validate Hoyt and Budman's (1996) contention that therapists are concerned about income reductions; these therapists reported that they were effected by changes to the actual therapy process and the perceived negative effect on their clients

The National Advisory Mental Health Council (1998) found that professionals were concerned about access to and quality of care and consumer-provider awareness. Quality of care or care effectiveness was a prominent theme in this study. Miller (1996) analyzed two studies comparing managed care and fee-for-service insurance and found that patients in the former fared worse at outcome and more frequently deteriorated in their level of functioning. Therapists in this study believe that quality of care has declined since managed care involvement through effects on the therapist (distractions and workload), decreased client investment and time spent in therapy, and the effect this has on client's ability to gain insight into problems and make relevant behavior changes.

A quality of care issue to emerge in this analysis involved the therapeutic relationship. Interviewees believed the pressures from managed care to assess problems quickly, for treatment plan development, and begin treatment quickly, due to time constraints, have adversely effected the therapeutic relationship deemed important as a conduit of client change. Research suggests that a positive therapeutic relationship, often labeled a nonspecific variable of change, is important for a successful therapy outcome (Granello and Witmer, 1997; Lambert and Bergen, 1994; Wilson, 1995).

Shapiro (1996) wrote about the triangle created by managed care involvement, noting it interferes with the trust and privacy necessary to enact change. The therapeutic

alliance is a necessary part of developing that relationship and the trust that facilitates change (Austad et. al., 1998; Yalom, 1985). The pull between aligning with patients and managed care, a significant problem when managed care is the primary payer of care, hampers the development of the relationship, especially for the therapist.

Bilynsky and Vernaglia (1998) wrote about the pull between the demands of patient care and managed care policies, a position that compromises the unilateral ethical dedication of therapists to their clients. According to the participants in this study, clients, who have come to view their therapy as short-term, are not as willing to fully invest in any part of the therapy relationship. In contrast, Cummings et. al. (1998) argue that the status of the therapeutic relationship is an issue that has outgrown its usefulness.

Interviewees believed there was a usurping of their clinical decision-making power. This has been documented by previous writers (Anders, 1996; Newman, 1998, November). Murphy et. al. (1998) and Chodoff (1996) found that a majority of surveyed therapists were concerned about loss of control over treatment decisions. Interviewees were concerned that clinically disinterested parties directed therapeutic care when the former remain legally and ethically responsible for client well-being (Keith-Spiegel and Koocher, 1985; Moldovsky, 1996). Some of this reflected egoistic threats to referent power but appeared to be more about the disregard for their clinical ability, as the specialist who intimately knew a client's dynamics, to make treatment decisions.

Income and money emerged as another theme in this study. Interviewees regarded profit-enhancing activities as the root of managed care's procedures and regulations to restrict care. Participants agreed that cost-containment is necessary to stave off rising health care costs but believed that profits were managed care's motivating reason to deny

continuation of therapy sessions (Newman and Tejada, 1996) and refer patients to less expensive clinicians, usually social workers (Bilynsky and Vernaglia, 1998; Kaiser Family Foundation, 2000, February). Like the interviewees in this study, Miller (1996) asserts that managed care only redirects premium dollars into their own hands.

Another quality control issue to emerge in this analysis concerned the length of psychotherapy approved by managed care. Consumer Reports (1995) found that longer psychotherapy was associated with better outcome. The interviewees were in agreement. There was strong concern that mental health outpatient therapy has been truncated to a level that is decreasing the quality of that care. This is consistent with other writers and researchers (Giles and Marafiote, 1998; Karon, 1995; National Advisory Mental Health Council, 1998; Kaiser Family Foundation, 2000, February).

Frasier (1996) noted that prepayment insurance systems create financial incentives to under-treat. Interviewees also believed that, especially for psychiatrists, under-treating is increasing in the form of decreased session length, increased use of medications, and counter-transference reactions that inadvertently effect patients through declining emotional and physical availability. Kiesler (2000), an advocate of short-term therapy because more care reaches more people, notes that quality is an issue when therapy is too short. Interviewees believed that managed care restrictions force one to provide crisis-intervention or Band-Aid help. Anders (1996) said, "Outpatient therapy can be truncated to the point that suicide prevention becomes the only goal" (p.157).

The interviewees in this study provided conflicting evidence about managed care's effect on the approaches and techniques they use to treat clients. The conflict may be an expression of differences between those therapists in terms who try to navigate

around managed care rules and those who avoid the system entirely, continuing therapy by negotiating fees with clients. Gold and Shapiro (1996) observed a sharp increase in identification with cognitive-behavioral approaches and a decrease in psychodynamic approaches for those therapists involved with managed care. The social worker and nurse practitioner in this study were more likely to adopt cognitive or behavioral techniques; possibly a function of training, gender, or financial need relative to one's degree.

Like the therapists in this study, Persons and Silberschatz (1998) stress that many clients do not meet DSM-IV diagnostic criteria and therefore EVT or EST cannot easily be applied; the heterogeneity of client problems suggests the need for individualized treatment plans with eclectic treatments. Goldfried and Wolfe (1998) and Jacobson and Christensen (1996) agree that controlled efficacy research and RCT cannot fully inform actual practice though managed care may use this data as the basis of decision-making criteria. Mintz et. al. (1996) point out that empirical research often excludes individuals with mixed or multiple problems. Like Therapist E said, many clients have Axis II diagnoses or characteristics that are strong impediments to change.

Research, regarding the relative efficacy and effectiveness of different therapy approaches, is inconclusive. Many authors have found no difference between approaches (Borkovec and Castonguay, 1998; Lambert and Bergen, 1994; Wampold, 1997); others have found a superiority for cognitive and behavioral approaches (Chambless, 1998; Chambless and Hollen, 1998; Weisz et. al., 1995). EVT and EST research supports the goals of managed care companies; specific, targeted short-term therapy (Calhoun et. al., 1998). As Seligman (1995) and others have pointed out, data from controlled, laboratory research may inform practice less than in context, clinically-relevant studies.

Sperry and Prosen (1998) wrote that managed behavioral health care insurance has altered the therapy process for clients and therapists by altering the boundaries and roles therein; when therapists are too active early in the therapy relationship, suggestions and advice can be inappropriate in timing and nature. The therapists in this study did not express concerns about boundaries specifically; they were worried that healthy coping skills cannot be facilitated without sufficient time to develop a positive transference and client trust as well as time for clients to try new behaviors resulting from insights gained.

Another theme involved interviewees agreement that clients need time to move to a successful therapy outcome; coupled with the clinical time that is now used for managed care paperwork and telephone calls, in-session clinical time has been greatly decreased. The decreased time available originated from the restrictions on care imposed by managed care; restrictions that therapists believed were related to cost-containment and profit-enhancing activities by the insurance companies.

When one combines this issue with concerns about confidentiality and privacy, usurping of clinical decision-making power, and reductions to personal income, the effects of managed care on the processes of the therapy begin to emerge. Therapists and clients become less invested. Therapists are pressured into adopting treatment strategies they do not believe best facilitate client change and growth. Substantial time is spent trying to manipulate managed care regulations so clients can receive necessary treatment.

When frustration and distraction built to a sufficient point, they abandoned working with managed care systems, negotiated reduced fees with clients, and continued a client's therapy as they saw fit. Money factored into their decisions but the interviewees appeared more willing to reduce their fees so they could maintain control of treatment and

conduct work they found satisfying; short-term or long-term therapy, family-systems dynamic, or cognitive-behavioral etc.. They wanted decision-making control over the clinical care they provided and for which they were ethically and legally liable.

Researcher's Account of the Experience

This researcher's account was derived from the annotations, memos and reports developed in the computer program QSR-N5. Part of the account was contained in a separate Microsoft Word program where weekly journal entries catalogued the progression of thought as the project unfolded. Initially, gaining a clear understanding of the process and procedures of qualitative analysis seemed overwhelming. When one is trained in quantitative methodology, the shift to qualitative analysis requires a change in attitude and comfort with the ambiguity of qualitative methods. Following completion of the fourth tutorial book about qualitative analysis, anxiety began to wane. A conceptual understanding developed and, after learning about this methodology, this researcher felt comfortable beginning the data collection procedures.

The first problem encountered involved acquiring participants for the study. Approximately 40-50 telephone calls were made to professionals from each of the four disciplines that provide psychotherapy, evenly distributed across fields. Names were acquired through professional association, professional membership directories, and the telephone book. Nine individuals agreed to participate. Many individuals did not return first or follow-up calls. Seven did not qualify for this study either because they did not spend sufficient amount of private practice or they were not practicing enough years post-graduate. The majority that declined provided a number of explanations ranging from not

participating in managed care to not having sufficient time to be interviewed; future investigations might explore if fear of managed care bore on practitioner's decisions.

Analyzing the first transcript was very cumbersome; the process was lengthier than anticipated. Rather than elicit the aid of outside people, this researcher transcribed the interviews alone for two reasons: to gain a better understanding of the material therein and to maintain the confidentiality of the participants. It took a considerable amount of time to complete the initial data analysis of the first interview. Choosing names for categories was difficult because of the inexperience brought to the project.

These problems diminished with each successive interview primarily because category labels repeated and information overlapped; a coherence to the data developed as themes emerged. Eventually, themes could be identified during the actual interviews. By the completion of the sixth interview, this researcher had reached a confidence and comfort level in the data collection and analysis process. Patterns emerged and became clearer. Writing the descriptions and themes was not insurmountable but lengthy.

The time factor was perhaps the most difficult part of this project. A much longer time period was required for this study because of the lack of a specific research base from which to draw, the time involved with learning the qualitative approach and mentality, the time involved with transcriptions, coding, and analysis, and the time involved in the final write-ups. Concomitant with the time factor, the length of the narrative of this study was surprising, exacerbated by the lack of a specific and decisive literature base from which to draw but also related to the space required to adequately convey participant's experiences. Completing the project was rewarding and relieving.

Future Research or Studies

This study was an exploration into the dynamics, relevant factors, concerns, and effects that managed behavioral health care insurance systems has on the psychotherapy process through the agent of the psychotherapist. A number of concerns and process effects have been outlined and developed. The commonalties among the interviewees suggest that numerous avenues exist for further analysis of the impact of managed care.

A clearer understanding of client perceptions and concerns are a natural direction for future studies. Possibly because it was not the focus of this study, the interviewees spoke only briefly about concerns their clients had expressed about managed care; the quality and time spent with managed care panel therapists, time spent on the telephone addressing benefit and payment problems, difficulty securing appointments with therapists, unwillingness to invest in a therapy process that might be very short, and financial constraints. A qualitative examination of these issues would open the door to understanding the need for changes from this side of the therapeutic dyad.

Uniform empirical measures of quality of care are lacking (National Advisory Mental Health Council, 1998; Miller and Farber, 1996). Current studies often employ effect size estimates of comparisons between treatment and control groups on narrow, compartmentalized outcome measures (Coursey, et. al., 1997) that, as Lipsey and Wilson (1993) suggest, are not clinically useful. From these studies, the general clinical effectiveness of psychotherapy over control treatments or no treatment has been established (Consumer Reports, 1995, November; Lambert and Bergen, 1994; Shadish et. al., 1997; Shadish and Ragsdale, 1996; Shadish and Sweeney, 1993; Weisz et. al., 1995).

A number of authors suggest that psychotherapy outcome literature would benefit from measuring general functioning and quality of life in additions to symptom change; additionally, longer-term therapies are often not included in efficacy research because of time and financial constraints (Clambless and Hollen, 1998; Lambert and Cattini-Thompson, 1998; Lunnen and Ogles, 1998; Schneider, 1999). This is consistent with the opinions of the participants in this study who felt that managed care simplified therapy by focusing on symptoms that were not useful indicators of client well-being and detrimental to gauging that change; the proof of therapy's success lie with the clients and therapists involved, in terms of general functioning, happiness, and positive coping skills. Fair comparison of the different therapies requires uniform measures of change that include both explicit symptoms and more subjective measures of well-being and change.

Miller (1996) advocates empirical focusing on the effects of time limits on therapy outcome, using clinically meaningful measures, because a minimum amount of psychotherapy is a precondition for successful outcome. In light of interviewees concerns that clinical effectiveness is compromised with ultra-brief treatment, this avenue clearly warrants further investigation. Time-limited therapy has been proven to be successful when clinically indicated (Howard et. al., 1986; Kopta et. al., 1992) as has longer-term approaches (Consumer Reports, 1995; Lambert and Cattini-Thompson, 1996; Svartberg and Stiles, 1991). Treatment length research would benefit from adding managed care variables to the investigations to pinpoint any unique interactions caused by its presence.

Other levels of mental health care need to be examined. Interviewees generally agreed that managed care regulations have resulted in premature discharge from hospital inpatient psychiatric units. The relevant processes for these patients and the professionals

serving them need examination as well because of the unique techniques, focus, and goals employed in the inpatient setting. Intensive outpatient and partial hospitalization programs could also be examined since these levels of care are being used more frequently used in lieu of hospitalization when possible because of the lower cost.

The entire spectrum of mental health services has been impacted by managed care involvement. Wide-scale examination of the processes involved would be facilitated by use of quantitative measures of the relevant variables; until a clearer understanding of these variables is known, this undertaking will need to wait. The uniqueness of managed care systems, and the new dynamics they have created for the therapy process, suggest that examining these issues fairly and productively would, at least for the present, require further use of qualitative measures. The development of standardized questionnaires awaits a fuller understanding of these issues. Perhaps, as the efficacy and effectiveness debate suggests, qualitative analysis can best facilitate these ends throughout.

The data resulting from this analysis guard against the development of causal or theoretical models of the impact of managed care on outpatient psychotherapy because the absence of a research base led to an inquiry procedure and goal that was exploratory in nature. Future investigations could attempt theory building and increase the chances of developing interventions to abate negative implications for psychotherapy from managed care involvement. The results of this analysis suggest the following considerations.

The rules and regulations of managed care set in motion a number of parallel and consecutive events that impact the therapy process. Financial restrictions effect the person of the therapist, the client and the relationship between them. Time constraints on the length of therapy, possibly related to managed care cost-containment strategies, alter the

therapist's focus and goals during therapy sessions. Some therapists work around these constraints by manipulating the system. The converging result of these factors is possibly less effective care for the patients services through managed care. A causal or theoretical model like this one warrants further investigation to assess which aspects can direct public policy and thereby enhance the quality of care the patient receives.

The present analysis suggests that a number of areas for the professional alone warrant further examination, regardless of the level of care examined. Ethical and legal issues are strong concerns for the professional. All of the therapists interviewed here expressed conflict over perceived ethical violations. The concerns interfere with the role therapists are attempting to perform by forcing them into creative behaviors to avoid those violations or add a triangulated dynamic into the treatment through a conflict of allegiance between their patients and the managed care insurance companies.

Money and financial issues also took a prominent place for the interviewees in this study. If financial issues precipitate a number of detrimental effects for therapists that eventually impact on client care, examining those problems is definitely warranted. These interviewees have suggested a flat rate of annual benefits, smaller than traditional plans, as one potential means of changing the system toward something more feasible for themselves as professionals trying to make a living. Since managed care originated as a response to rising health care costs, it is a logical extension to examine all of the cost factors that continue to plague the system. This position necessitates looking at the long-term effects of shorter and confabulated psychotherapeutic services.

Kaiser Permanente Health Plan discovered the value of mental health services for preventing over-utilization of general health care facilities by people with somatic

complaints (Frasier, 1996) and reducing absenteeism from work (Karon, 1995). Further examination of the medical offset effect concept and its relation to psychotherapy quality and effectiveness warrants further study. Kiesler (2000) noted the considerable cost when patients reenter the system for second treatments of the same problem. If recidivism is increasing, a question not answered in this study, and general health is detrimentally effected, then long-term health care costs would benefit from answering these questions.

The lack of general consensus about the impact of managed care on the techniques or approaches used in psychotherapy would benefit from further examination. The focus of psychotherapy researcher needs to include the recipients of that care. Complete assessment of the quality of that care requires a thorough understand of the processes and factors contributing to it. We need more consistent and comprehensive measures of the efficacy and effectiveness of psychotherapy and the quality of care.

EVT and EST research may only tell us what works under carefully controlled situations with therapies amenable to quantification (Chambless, 1998; Chambless and Hollen, 1998). A global standard of care can only come after quality and effectiveness are carefully understood. Beutler and Davidson (1995) point out that empirical standards are chosen depending upon one's theoretical orientation. These authors agree that outcome research must have clinical significance or face validity as well.

It is worthwhile to investigate these issues with a group of licensed professionals who have been working independently for a shorter period of time post-graduate. The interviewees in this study were chosen only if they met the minimum criteria of five years of post-licensing work the purpose of which was to ensure that interviewees could access changes since managed care's origination; the comparison required actual clinical

experience pre-managed care involvement. A different set of factors and issues may exist for those practitioners who only know working with managed care.

Some of the interviewees in this study speculated that professionals who stay with managed care do so because they are new and need to develop their practices or cannot exist without those referrals. The issues, concerns or problems may be different for them because managed care restrictions are all they have known. Also, younger therapists have been trained in therapeutic approaches and models that accommodate the expected influence of managed care; short-term therapy has taken a more prominent place in training and supervisory institutions. These issues clearly warrant further investigation.

Finally, future investigations could benefit from employing an external audit during the data analysis process. An external audit would provide additional evidence of the credibility of qualitative findings because, in such an audit, an external reviewer offers a verification check on each data collection, management, and analysis step performed by the researcher. In this analysis, member checks to verify the textural and structural meanings derived from participant's experiences were the primary avenue chosen to furnish credibility; an audit would have enhanced those findings.

Outcomes and Conclusions in Terms of Social and Professional Implications

Therapist D expressed anger toward the professional associations who initially backed managed care by urging member support; professionals need to join together and approach managed care as a united group for change to be enacted. NJPA and APA have begun to move in this direction (Sullivan, 2000, March); patient and professional

advocacy groups are springing up around the country and are urged to do so (Anders, 1996; Bilynsky and Vernaglia, 1998; Broskowski, 1991).

NJPA made a May, 2001 request for financial support to approach the federal legislature for complete mental health parity. Full mental health parity was a change desired by Therapist F; complete equity with medical procedures in terms of treatment and reimbursement provided. Mental health parity, in theory, exists on the books with regard to total annual and lifetime coverage limits (H.R. 4058); the law, however, does not regulate the procedures for actually providing for use of those benefits.

Until federal reforms are enacted, suing managed care has become the primary avenue professionals use to counter managed care restrictions (Anders, 1996; Newman, 1997, November; Rabasca, 2000, February; Sleek, 1998a, February). Because the ERISA protection still exists, APA's legal strategy is to expose the degree that managed care companies make treatment decisions, thereby placing care responsibility into their hands as well (Alvarez, 1998, September). This approach has been advocated by Giles and Marafiote (1998) and Sank (1997) who think managed care needs to be held accountable for untoward treatment outcomes. Pipal (1996) thinks therapists need to surpass a fear of expulsion from managed care panels in order to legally contest them.

At the time of this writing, federal regulation of managed care is at a standstill. Congress is focused on addressing the legal and financial concerns expressed by professional, associations, and consumer advocacy groups (H.R. 2723; H.R. 2926; H.R. 4058; H.R.3222; Public Papers of the Presidents, 1997). Farberman (1999, February) summarized a 1999 Kaiser Family Foundation and Harvard University poll; 86% of

Americans favored government regulation of managed care. Kaiser Family Foundation (2000) found that 80% of consumers favored congressional action with managed care.

Two-thirds of Americans have expressed a willingness to pay an extra 10 dollars a month for expanded health care services (Sleek, 1998, June). The strongest government reaction to managed care came in July 1999 when the Senate passes the "Patients' Bill of Rights Plus Act (S. 1344) creating stricter control over medical record privacy and an external appeal process where noncompliance results in 10,000 dollar fines per incident.

The interviewees in this study expressed a desire to change insurance benefits to a system with a flat annual rate, albeit lower than what traditional insurance offered. Part of this change would increase patient care dollars and part would increase payment to practitioners while keeping health care costs contained. The continual decrease in the amount of premiums spent on direct patient care is alarming to professionals from all health care disciplines (Kaiser Family Foundation, 1999; Karon, 1995).

The changes expressed by the participants in this study are laudable. But without empirical data to support them, managed care advocates will view professionals' opinions as simple complaints about accountability and losses of power and income. Government regulation may be more forthcoming with an empirical data base from which to draw; it is difficult for health care policy-makers to advocate for changes in the system without hard-core facts and numbers to back them. Empirical investigation into these processes and issues appears to be the most promising route to change.

References

Alvarez, T. (1998, September). Psychologists file suit against managed care entities. APA Monitor.

American Counseling Association. ((1997). Code of Ethics and Standards of Practice. Annapolis: ACA Distribution Center.

American Nurses Association. (1985). Code For Nurses: with Interpretive Statements. Washington, DC: American Nurses Publishing.

American Psychiatric Association. (1998). The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry. Washington, DC: American Psychiatric Association.

American Psychological Association. (1992). Ethical Principles of Psychologists and Code of Conduct. Washington, DC: American Psychological Association, Inc.

Anastas, L. Larimore (1999, August). When managed care means mediocre care. Newsweek, 10-11.

Anders, G. (1996). Health against wealth: HMOs and the breakdown of medical trust. New York: Houghton Mifflin Company.

Anonymous. (1999, July 5). What's up, unionized doc? Newsweek, 10.

Anonymous. (1999, May). APA statistics task force prepares to release recommendations for public comment. APA Monitor, 30(5), p. 9.

Anonymous. (1998, November) APA helps prompt suit against California MCOs. APA Monitor, 29(11), pp. 1, 21.

Anonymous2. (1998, November) How APA works with states to create legal precedents. APA Monitor, 29(11), p. 21.

Anonymous. (1995, November). Mental health: Does therapy help? Consumer Reports, 734-739.

Austad, C. S., Hunter, R. D., & Morgan, T. C. (1998). Managed health care, ethics, and psychotherapy. Clinical Psychology: Science and Practice, 5(1), 67-76.

Barletta, J., Beamish, P., Patrick, M., Anderson, K., & Pappas, N. (1996). Obsessive- Compulsive Disorder: Emerging Standard of Care. Psychotherapy in Private Practice, 15(1), 19-31.

Benjamin, L.T. and Baker, D.B. (2000). Boulder at 50: Introduction to the section. American Psychologist, 55(2), 233-236.

Beutler, L.E. & Davidson, E.H. (1995). What standards should we use. (In S.C. Hayes, V.M. Follette, R.M. Dawes, & K.E. Grady Eds.), Scientific Standards of Psychological Practice: Issues and Recommendations (p.11-24). PUBLISHER AND TOWN

Bilynsky, N. S., & Vernaglia, E. R. (1998). The ethical practice of psychology in a managed-care framework. Psychotherapy, 35(1), 54-68.

Borkovec, T.D. & Castonguay, L.G. (1998) What is the scientific meaning of empirically supported therapy? Journal of Consulting and Clinical Psychology, 66(1), 136-142.

Broskowski, A. (1991). Current mental health care environments: Why managed care is necessary. Professional Psychology: Research and Practice, 22(1), 6-14.

Calhoun, K.S., Moras, K., Pilkonis, P.A., & Rehm, L.P. (1998) Empirically supported treatments: Implications for training. Journal of Consulting and Clinical psychology, 66(1), 151-162.

Castle Connolly Medical Advisory Board (1997). The ABC's of HMO's: How to get the best from managed care. New York: Castle Connolly Medical Ltd.

Castonguay, L.G., Goldfried, M.R., Wisner, S., Raue, P.J., & Hayes, A.M. (1996) Predicting the effect of cognitive therapy for depression: A study of unique and common factors. Journal of Consulting and Clinical Psychology, 64(3), 497-504.

Chafee, Sen. J. (1999, July 13). U.S. Senate Live. Washington, DC: C-SPAN.

Chambless, D.L. & Hollon, S.D. (1998). Defining Empirically Supported Therapies. Journal of Consulting and Clinical Psychology, 66(1), 7-18.

Chambless, D. (1998). Empirically Validated Treatments. (In G.P. Koocher, J.C. Norcross, & S.S. Hill III, Eds.) Psychologists' Desk Reference. (p.22-25) New York: Oxford University Press.

Chodoff, P. (1996). Ethical dimensions of psychotherapy: A personal perspective. American Journal of Psychotherapy, 50(3), 298-310.

Clay, R.A. (1998, August). Outcries over managed care spur action. APA Monitor, 29(8), p. 28.

Clay, R.A. (1998, April). Consumers are key to battling the abuses of managed care. APA Monitor, 29(4), p. 26.

Clay, R.A. (1998, March). Public backlash buoys antimanaged-care laws. APA Monitor, 29(3), p. 24.

Clum, G.A., Clum, G.A., & Surls, R. (1993). A meta-analysis of treatments for panic disorder. Journal of Consulting and Clinical Psychology, 61(2), 317-326.

Consumer Reports (1995, November). Mental health: Does therapy help?. Consumer Reports, 734-739.

Cone, J. D., & Foster, S. L. (1993). Dissertations and theses from start to finish: Psychology and related fields. Washington, DC: American Psychological Association.

Congress: H.R. 2926 (1999, September). Comprehensive access and responsibility in health care act of 1999. House of Representatives, p. .

Congress: H.R. 1133 (1999, August). Bipartisan consensus managed care improvement act of 1999. House of Representatives, p. .

Congress: S. 1344 (1999, July). Patients' bill of rights plus act. Senate, p. .

Congress: H.R. 1133 (1999, March). Comprehensive managed health care reform act of 1999. House of Representatives, p. .

Congress: H.R. 4058 (1996, September). Mental health parity act of 1996. House of Representatives, p. .

Congress: H.R. 3222 (1996, March). Hippocratic oath and patient protection act of 1996. House of Representatives, p. .

Coursey, R.D., Alford, J., & Safarjan, B. (1997). Significant Advances in Understanding and Treating Serious Mental Illness. Professional Psychology: Research and Practice, 28(3), 205-216.

Creswell, J. W. (1998). Qualitative inquiry and research design: Choosing among five traditions. California: SAGE Publications, Inc.

Creswell, J. W. (1996). Research design: Qualitative and quantitative approaches. California: SAGE Publications, Inc.

Crits-Christoph, P., Frank, E., Chambless, D.E., Brody, C., & Karp, J.F. (1998). Training in Empirically Validated Treatments: What Are Clinical Psychology Students Learning? Professional Psychology: Research and Practice, 26(5), 514-522.

Cummings, N. A., Budman, S. H., & Thomas, J. L. (1998). Efficient psychotherapy as a viable response to scarce resources and rationing of treatment. Professional Psychology: Research and Practice, 29(5), 460-469.

Davidson, G.C. (1998) Being bolder with the boulder model. Journal of Consulting and Clinical Psychology, 66(1), 163-167.

DeLeon, P.H., VandenBos, G.R., & Bulatao, E.Q. (1991) Managed mental health care: A history of the federal policy initiative. Professional Psychology: Research and Practice, 22(1), 15-25.

Department of Health and Human Services. HHS: Historical Highlights.

Dickson, D. T. ((1995). Law in the health and human sciences: A guide for social workers, psychologists, psychiatrists, and related professionals. New York: The Free Press.

Dobson, K.S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. Journal of Consulting and Clinical Psychology, 57(3), 414-419.

Fals-Stewart, W. (1993). Recent Advances in the Psychotherapeutic Treatment of Obsessive-Compulsive Disorder. Psychotherapy in Private Practice, 12(4), 1-15.

Farberman, R. (1999, February) Americans report conflicting attitudes about managed care. APA Monitor, 30(2).

Foxhall, K. (2000, June). Victories for parity. APA Monitor, 31(6), 16 and 18.

Foxhall, K. (1999, October). APA supports lawsuits to hold managed care accountable. APA Monitor, 30(9), 29.

Frank, R.G. & VandenBos, G.R. (1994). Health care reform: The 1993-1994 evolution. American Psychologist, 49(10), 851-854.

Frasier, J.S. (1996). All that glitters is not always gold: Medical offset effects and managed behavioral health care. Professional Psychology: Research and Practice, 27(4), 335-344.

Freud, S. (1965). The interpretation of dreams. New York: Avon Books.

Frisch, M.B., Cornell, J., Villanueva, M., & Retzlaff, P.J. (1992) Clinical validation of the quality of life inventory: A measure of life satisfaction for use in treatment planning and outcome assessment. Psychological Assessment, 4(1), 92-101.

Fulton, A. (2000, July 5). Personal Communication.

Fulton, A. (2000, June). Senate passes limited HMO liability after defeating dem plan. National Journal's Congress Daily AM, 10-11.

Garfield, S.L. (1998). Some Comments on Empirically Supported Treatments. Journal of Consulting and Clinical Psychology, 66(1), 121-125.

Giles, T. R., & Marafiotte, R. A. (1998). Managed care and the practitioner: A call for unity. Clinical Psychology: Science and Practice, 5(1), 41-50.

Goldfried, M.R. & Wolfe, B.E. (1998). Toward a More Clinically Valid Approach to Therapy Research. Journal of Consulting and Clinical Psychology, 66(1), 143-150.

Goldstein, A. (1999, October). Managed scare: Everyone hates HMO's. But are they really to blame. The Star-Ledger: Perspective, 1 and 12.

Goodman, M., Brown, J., & Deitz, P. (1992). Managing managed care: A mental health practitioner's survival guide. Washington, DC: American Psychiatric Press, Inc.

Granello, P.F. & Witmer, J.M. (1998). Standards of care: Potential implications for the counseling profession. Journal of Counseling and Development, 76, 371-380.

Hayes, S.C. (1995). What do we want from scientific standards of psychological practice? (In S.C. Hayes, V.M. Follette, R.M. Dawes, & K.E. Grady Eds.), Scientific Standards of Psychological Practice: Issues and Recommendations (p.11-24). PUBLISHER AND TOWN

Howard, K.L., Krause, M.S., Saunders, S.M., & Kopta, S.M. (1997). Trials and tribulations in the meta-analysis of treatment differences: Comment on Wampold et al. (1997). Psychological Bulletin, 122(3), 221-225.

Hoyt, M. F., & Budman, S. H. (1996). Fear and loathing on the managed care trail: A response to Pipal (1995). Psychotherapy, 33(1), 121-123.

Humphreys, K. (1996). Clinical psychologists as psychotherapists: History, future and alternatives, American Psychologist, 51(3), 190-197.

Jacobson, N.S. & Christensen, A. (1996). Studying the effectiveness of psychotherapy: How well can clinical trials do the job? American Psychologist, 51(10), 1031-1039.

Kaiser Family Foundation (2000, June). National survey of consumer experiences with health plans: Summary of findings and chart pack. The Henry J. Kaiser Family Foundation, 1-26.

Kaiser Family Foundation (2000, February). The public, managed care, and consumer protection: Kaiser public opinion update. The Henry J. Kaiser Family Foundation, 1-2.

Kaiser Family Foundation (1999, March). The Kaiser changing health care marketplace project: A financial overview of the managed care industry. Market Facts, 1-4.

Karon, B.P. (1995). Provision of psychotherapy under managed health care: A growing crisis and national nightmare. Professional Psychology: Research and Practice, 26(1), 5-9.

Kazdin, A.E., & Bass, D. (1989). Power to detect differences between alternative treatments in comparative psychotherapy outcome research. Journal of Consulting and Clinical Psychology, 57(1), 138-147.

Keith-Spiegel, P., & Koocher, G. P. (1985). Ethics in psychology: Professional standards and cases. New Jersey: McGraw-Hill, Inc.

Kiesler, C.A. (2000). The next wave of change for psychology and mental health services in the health care revolution. American Psychologist, 55(5), 481-487.

Kirk, J., & Miller, M. L. (1986). Reliability and validity in qualitative research. California: SAGE Publications, Inc.

Kvale, S. (1996). InterViews. California: SAGE Publications, Inc.

Lakin, M. (1991). Coping with ethical dilemmas in psychotherapy. New York: Pergamon Press.

Lambert, M.J. & Cattini-Thompson, K. (1998) Key principles in the assessment of psychotherapy outcome. (In G.P. Koocher, J.C. Norcross, & S.S. Hill III, Eds.) Psychologists' Desk Reference. (p.22-25) New York: Oxford University Press.

Lambert, M.J., Chiles, J.A., Kesler, S.R., & Vermeersch, D.A. (1998). Compendium of current psychotherapy treatment manuals (In G.P. Koocher, J.C. Norcross, & S.S. Hill III, Eds.) Psychologists' Desk Reference. (p.22-25) New York: Oxford University Press.

Lincoln, Y.S. & Guba, E.G. (1985). Naturalistic Inquiry. California: SAGE Publications, Inc.

Lipchik, E. (1994, March/April). The rush to be brief. Networker, 35-39.

Lipsey, M.W. & Wilson, D.B. (1993). The efficacy of psychological, educational, and behavioral treatment: Confirmation from meta-analysis. American Psychologist, 48(12), 1181-1209.

Lunnen, K.M. & Ogles, B.M. (1998). A multiperspective, multivariable evaluation of reliable change. Journal of Consulting and Clinical Psychology, 66(2), 400-410.

Marshall, C. & Rossman, G.B. (1999). (3rd Edition). Designing qualitative research. California: SAGE Publications, Inc.

Matt, G.F. (1989). Decision rules for selecting effect sizes in meta-analysis: A review and reanalysis of psychotherapy outcome studies. Psychological Bulletin, 105(1), 106-115.

Miller, B. & Farber, L. (1996). Delivery of mental health services in the changing health care system. Professional Psychology: Research and Practice, 27(5), 527-529.

Miller, I. J. (1996). Ethical and liability issues concerning invisible rationing. Professional Psychology: Research and Practice, 27(6), 583-587.

Miller, I. (1996). Managed care is harmful to outpatient mental health services: A call for accountability. Professional Psychology: Research and Practice, 27(4), 349-363.

Mintz, J., Drake, R.E., & Crits-Christoph, P. (1996). Efficacy and effectiveness of psychotherapy: Two paradigms, one science. American Psychologist, 51(10), 1084-1085.

Moody, M. (1999, Winter). You can make a difference: Ethics code task force seeks student input. American Psychological Association of Graduate Students, 11(1), p.1.

Moustakas, C. (1994). Phenomenological research methods. California: SAGE Publications, Inc.

National Association of Social Workers. (1996). Code of ethics. Washington, DC National Association of Social Workers.

National Center For Health Statistics (1999). Health, United States, 199./9, with health and aging chartbook.

National Advisory Mental Health Council (1998, May). Parity in financing mental health services: managed care effects on cost, access, and quality. An interim report to congress by the national advisory mental health council. Department of Health and Human Services. National Institutes of Health. National Institute of Mental Health, 1-53.

Newman, F.L. & Tejada, M.J. (1996). The need for research that is designed to support decisions in the delivery of mental health services. American Psychologist, 51(10), 1040-1049.

Newman, R., Ph.D., JD. (1998, November). Lawsuits take aim at MCO abuses. APA Monitor, 29(11), p. 25.

Newman, R., Ph.D., JD. (1998, February). The 1-percent solution. APA Monitor, 29(2), p. 31.

Newman, R., Ph.D., JD. (1997, November). Managed-care suit goes to litigation. APA Monitor, 28(11), p. 26.

Newsweek (1999, July). What's up, unionized doc? Crib Sheet, 10.

Office of Senator Edward M. Kennedy (2000, June). Differences between Norwood-Dingell H.R. 2723 and S. 6 (introduced 1/19/99). Office of Senator Edward M. Kennedy, 1-3.

Packard, T. (1995). Making the case. (In S.C. Hayes, V.M. Follette, R.M. Dawes, & K.E. Grady Eds.), Scientific Standards of Psychological Practice: Issues and Recommendations (p.11-24). PUBLISHER AND TOWN

Pallak, M.S. (1995). Managed-care and outcomes-based standards in the health care revolution. (In S.C. Hayes, V.M. Follette, R.M. Dawes, & K.E. Grady Eds.), Scientific Standards of Psychological Practice: Issues and Recommendations (p.11-24). PUBLISHER AND TOWN

Pederson, D. (1999, July 26). Is your HMO too stingy? Newsweek, 56.

Persons, J.B. & Silbershatz, G. (1998) Are results of randomized controlled trials useful to psychotherapists? Journal of Consulting and Clinical Psychology, 66(1), 126-135.

Pipal, J. E. (1996). Without apology or fear: Reflections on Hoyt and Budman (1996) and managed mental health care. Psychotherapy, 33(1), 124-128.

Pipal, J.E. (1995). Managed care: Is it the corpse in the living room? An expose. Psychotherapy, 32(2), 322-332.

President's Advisory Commission (1998, July). Consumer protection and quality in the health care industry. Appendix A: Consumer bill of rights and responsibilities. President's Advisory Commission, pp. .

Public Papers of the Presidents (1997, November). Remarks announcing the health care "consumer bill of rights and responsibilities." U.S. Government Printing Office via GPO Access, p.1618-1621.

Rabasca, L. (2000, February). Two APA members sue managed-care companies on behalf of patient welfare. APA Monitor, 31(2), p. 30.

Rabasca, L. (1999, November). House gives patients right to sue managed care plans. APA Monitor, 30(10), p. 20.

Rabasca, L. (1999, July/August). Judge limits federal protections for managed-care company. APA Monitor, 30(7), p. 6.

Rabasca, L. (1999, February). Finding the right niche n new market. APA Monitor, 30(2), pp. 1, 10-11.

Rabasca, L. (1999a, February). APA supports suit against managed care. APA Monitor, 30(10), p. 29.

Rabasca, L. (1998, November). APA pursues test cases to set legal precedents. APA Monitor, 29(11), p. 20.

Rabasca, L. (1998, September). Bills to regulate managed care gain support. APA Monitor, 29(9), p. 23.

Richard's, L (2000). Using N5 in Qualitative Research. QSR International Pty Ltd.

Richard's, T. (2000). N5 Reference Guide. QSR International Pty Ltd.

Sank, L.I. (1997). Taking on managed care: One reviewer at a time. Professional Psychology: Research and Practice, 28(6), 548-554.

Schneider, K.J. (1999) Clients deserve relationships, not merely "treatments." American Psychologist, 54(3), 206-207.

Scolari (1999). Sage Publications Software. [Brochure]. California: Sage Publications Inc.

Seligman, M.E.P. (1995). The Effectiveness of Psychotherapy. The Consumer Reports Study. American Psychologist, 50(12), 965-974.

Shadish, W.R., Matt, G.E., Navarro, A.M., Siegle, G., Crits-Christoph, P., Hazelrigg, M.D., Jorm, A.F., Lyons, L.C., Nietzel, M.T., Robinson, L., Prout, H.T., Smith, M.L., Svartberg, M., & Weiss, B. (1997). Evidence that therapy works in clinically representative conditions. Journal of Consulting and Clinical Psychology, 65(3), 355-365.

Shadish, W.R. & Ragsdale, K. (1996). Random versus nonrandom assignment in controlled experiments: Do you get the same answer? Journal of Consulting and Clinical Psychology, 64(6), 1290-1305.

Shadish, W.R., Montgomery, L.M., Wilson, P., Wilson, M.R., Bright, I., & Okwumabua, T. (1993). Effects of family and marital psychotherapies: A meta-analysis. Journal of Consulting and Clinical Psychology, 61(6), 992-1002.

Shadish, W.R. & Sweeney, R.B. (1991). Mediators and moderators in meta-analysis: There's a reason we don't let dodo birds tell us which psychotherapies should have prizes. Journal of Consulting and Clinical Psychology, 59(6), 883-893.

Shearer, S., Ph.D. (1999, April). No patient protection without ERISA reform. APA Monitor, 30(4), p. 25.

Sleek, S. (1998, June). Americans want the right to sue for negligent care. APA Monitor, 29(6), p. 25.

Sleek, S. (1998, February). Managed-care battle waged on Capitol Hill. APA Monitor, 29(2), p. 24.

Sleek, S. (1998a, February). Managed-care lawsuit moves into next phase. APA Monitor, 29(2), p. 25.

Sleek, S. (1996, November). State laws are reining in managed care. APA Monitor, 27(11), pp. 1, 34.

Sleek, S. (1996a, November). State legislation aims to boost patient protections. APA Monitor, 27(11), p. 34.

Sperry, L., & Prosen, H. (1998). Contemporary ethical dilemmas in psychotherapy: Cosmetic psychopharmacology and managed care. American Journal of Psychotherapy, 52(1), 54-63.

Storch, R. (1996). Toward preserving the ethical integrity of the psychoanalytic process. Psychotherapy in Private Practice, 15(2), 33-42.

Sullivan, M. (2000, March). APA and states: A positive relationship. APA Monitor, 31(3), 49.

Svartberg, M. & Stiles, T.C. (1991). Comparative effects of short-term psychodynamic psychotherapy: A meta-analysis. Journal of Consulting and Clinical Psychology, 59(5), 704-714.

Vaillant, L. M. (1994). The next step in short-term dynamic psychotherapy: A clarification of objectives and techniques in an anxiety-regulating model. Psychotherapy, 31(4), 642-654.

Volz, J. (2000, March). Patient-protection battles continue on Capitol hill. APA Monitor, 31(3), 48-49.

Volz, J. (1999, September). Angered by managed care, practitioners look to unions. APA Monitor. pp. 1, 24.

Walter, J. I., & Peller, J. E. (1992). Becoming solution-focused in brief therapy. New York: Brunner/Mazel, Inc.

Wampold, B.E., Mondin, G.W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes." Psychological Bulletin, 122(3), 203-215.

Weisz, J.R., Donenberg, G.R., Han, S.S., & Weiss, B. (1995) Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. Journal of Consulting and Clinical Psychology, 63(5), 688-701.

Weisz, J.R., Weiss, B., Han, S.S., Granger, D.A., & Morton, T. (1995). Effects of psychotherapy with children and adolescents revisited: A meta-analysis of treatment outcome studies. Psychological Bulletin, 117(3), 450-468.

Wilson, G.T. (1995). Empirically validated treatment as a basis for clinical practice: Problems and prospects. (In S.C. Hayes, V.M. Follette, R.M. Dawes, & K.E. Grady Eds.), Scientific Standards of Psychological Practice: Issues and Recommendations (p.11-24). PUBLISHER AND TOWN

Wylie, M. S. (1994, March/April). Endangered species. Networker, 20-44.

Appendix AInitial Telephone Introduction

My name is Jami Messina. I am a doctoral candidate at Seton Hall University, the College of Education and Human Services, Department of Professional Psychology and Family Therapy. I am conducting a doctoral study about therapist's experiences of conducting psychotherapy within the guidelines of managed behavioral health care and would like to include you as a research participant in this study. I would like to take some time now to describe to you the purpose and procedure and what your participation would entail (this discussion will be limited to the equivalent information in the informed consent form). If this study is something you would be interested in, I would like to mail you a copy of the informed consent form for your review and schedule an appointment to meet with you and conduct the interview.

Appendix B

Informed Consent Form

Jami M. Messina, M.A.
34 Wedgewood Drive, Unit #49
Verona, NJ 07044
(973) 571-9878
Seton Hall University
College of Education and Human Services
Department of Professional Psychology and Family Therapy
Dr. S. Utsey, Mentor
(973) 761-9450

Participation Consent Form

“The Impact of Managed Mental Health Care on the Delivery of Outpatient
Psychotherapy:
A Qualitative Analysis”

The following information is provided to assist you in deciding whether you wish to participate in the present study. You should be aware that participation is completely voluntary and you are free to decide not to participate or to withdraw at any time without affecting your relationship with this researcher, this department, or the Seton Hall University.

The purpose of this study is to understand and describe the impact of managed mental health care on the delivery or process and perceived outcome of psychotherapy in the private sector. The focus of the analysis is on the perceptions and experience of the licensed psychotherapists who have five or more years experience in conducting private practice psychotherapy. The goal of the analysis is a more thorough understanding and description of the essential meanings and themes for practitioners conducting psychotherapy in private practice. The procedure involves an extended open-ended interview, from 1-2 hours, in which I would like to audio-tape the psychotherapist's verbal data, with her or his consent, and strategically analyze it with qualitative research methods. These interviews will be conducted at your convenience in your working environment.

At this stage in the research, managed mental health care is defined financial, reimbursement insurance plans for mental health services in which the provider of those services is required to receive authorization for initial care and ongoing treatment in order to receive financial remuneration for those services. Managed care here refers to all insurance plans in which treatment decisions are collaboratively made by insurance company personnel with the practicing therapist.

Please do not hesitate to ask any questions about the study either before participating in the study, during the time that you are participating, or after the interview is completed. I would be happy to share a summary of the findings with you when the research is completed. I ask that you note that your name or affiliations and any names, organizations, or institutions discussed, will not be associated with the research findings in any way and your identity as a participant will be known only to this researcher; you will be identified in any discussions and expose only as "Therapist (letter of the alphabet)." Your anonymity is completely guaranteed, during quoting of interview passages for dissertation writing and any manuscripts submitted for publications. The master key which identifies you with your code name will be destroyed at completion of this study. You will be afforded an opportunity to see a summary of the aggregate results, analyses, and interpretations, if you choose.

There are no risks and/or discomforts associated with this study. In the event that any discomfort arises for you, you may contact myself or Dr. Shawn Utsey, Project Mentor, from Seton Hall University for assistance. Both of these telephone numbers are provided at the top of this form.

The expected benefits associated with your participation in this study are the information gathered about the impact of managed mental health care on the psychotherapy process; the understanding of major issues and concerns about the process, the stimulation of future research into these processes, and the positive contributions to the psychotherapy literature that can be derived from them.

It is probable that you will be contacted for follow-up questions and information after the interviews are analyzed. If submitted for publication, a byline will indicate a general note of thanks to those psychotherapists who have contributed to this study, without reference to your name or affiliations.

This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Subjects Research. The IRB believes that the research procedures adequately safeguard the subject's privacy, welfare, civil liberties, and rights. The Chairperson of the IRB may be reached through the Office of Grants and Research Services. The telephone number of the Office is (973) 275-2974.

I have read the material above, and any questions I asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I may withdraw without prejudice at any time.

Signature of Participant

Date

Signature of Witness

Date

Appendix C

Protocol Form: Condensed Version

Pseudonym _____ Date _____
 Researcher _____ Time _____
 Place _____

I would like to remind you that my name is Jami Messina and I am a doctoral candidate at Seton Hall University, College of Education and Human Services, Department of Professional Psychology and Family Therapy. The purpose of this interview is to help me understand more fully the impact of managed mental health care on how you conduct psychotherapy or the actual process of psychotherapy. I am most concerned with your understanding and perceptions. My goal is to be able to describe the general or essential meanings and themes for you, the psychotherapist. This interview will provide me with the data to do that. There are no surveys or questionnaires involved; I want to gain a better understanding of this topic through this conversation. To help assure accuracy, I would like to tape this interview, with your consent. This will allow me to represent your experiences most accurately. Is that acceptable to you? Do you have any questions?

Descriptive Information

Participant

Physical Setting

Relevant Events and Activities

Noteworthy Dialogue

Question 1. What is it like to conduct psychotherapy when your clients have managed behavioral health care insurance?

Descriptive Notes

Reflective Notes

Question 2. What was your experience like to conduct psychotherapy prior to the involvement of managed behavioral health care insurance?

Descriptive Notes

Reflective Notes

Question 3. What differences do you experience between how you conduct psychotherapy when working with clients with managed behavioral health care and those clients without these kinds of insurance?

Descriptive Notes

Reflective Notes

Question 4. How has involvement with managed behavioral health care insurance affected the ways you conceptualize or understand client's problems?

Descriptive Notes

Reflective Notes

Question 5. How has involvement with managed behavioral health care insurance affected the techniques you use during psychotherapy?

Descriptive Notes

Reflective Notes

Question 6. How has involvement with managed behavioral health care insurance affected the goals you set for clients?

Descriptive Notes

Reflective Notes

Question 7. What unique ethical concerns do you experience when you work with clients who have managed behavioral health care insurance?

Descriptive Notes

Reflective Notes

Closing Question. I have no further questions. Do you have anything more you want to bring up, or ask about, before we finish the interview?

Descriptive Notes

Reflective Notes

Appendix D

Follow-Up Letter to Participants

Jami M. Messina, M.A.
34 Wedgewood Drive, Unit #49
Verona, NJ 07044
(973) 571-9878
Seton Hall University
College of Education and Human Services
Department of Professional Psychology and Family Therapy
Dr. S. Utsey, Mentor
(973) 761-9450

Follow-Up Letter to Participants

Dear _____:

Enclosed you will find the summary write-up of the interview I had with you. I would greatly appreciate it if you would read it over and provide your comments or input to me. My goal, in this write-up was to reflect your thoughts about managed care as closely to the original as possible. The summary was derived from the transcripts of your interview and my resultant analysis.

Please telephone me at the number above with your comments. If my summary has not accurately reflected your beliefs, feelings and intentions, I would want to speak to you, either by telephone or in person, which ever is more convenient for you, to correct my misinterpretations. Thank you again for your generosity with your time.

Sincerely,

Jami M. Messina, M.A.