To the Graduate Council:

I am submitting herewith a dissertation written by Ralph Warren Jr. entitled "*Psychodynamic Psychotherapists' Experience of Managed Care: Reconsidering Professional Autonomy and Ethics.*" I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Psychology.

Howard R. Pollio, Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Associate Vice Chancellor
and Dean of the Graduate School

PSYCHODYNAMIC PSYCHOTHERAPISTS' EXPERIENCE OF MANAGED CARE: RECONSIDERING PROFESSIONAL AUTONOMY AND ETHICS

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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Ralph Warren Jr.

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ABSTRACT

Mental health care services are becoming increasingly re-organized under what generally has become known as managed care. This study examined psychodynamic psychotherapists' experience of the impact of managed care on their conduct of long-term psychotherapy in an independent practice setting. An existential-phenomenological approach, which incorporated some concepts from Bourdieu's reflexive sociology, was used to investigate the experience of these psychotherapists. The purpose of this study was to describe the life-world of these psychotherapists and how their professional practice was affected by specific practices of managed care review. This inquiry aimed to articulate the needs and interests of psychotherapists and to demonstrate the relevance of this method of inquiry to decision-makers in the mental health system.

Empirical phenomenology guided the selection of research participants and data analytic procedures. Ten self-identified psychodynamic psychotherapists, five from Tennessee and five from Massachusetts, participated in this study. All participated in an open-ended interview about their experiences with managed care. Phenomenological thematic and hermeneutic narrative procedures were used to analyze these interviews.

Each participant discussed general situations related to the impact of managed care and specific transactions with managed care reviewers. Each interview was divided into a series of these situations/transactions. The analysis of interviews produced four themes describing the experience of managed care: *autonomy*, *change in therapeutic relationship*, *change in self*, and *ethical / moral stance*. Dynamic interactions of experiential themes were presented for each of the situations/transactions discussed by all ten participants.

Results were discussed with reference to common experiences and concerns of the participants and to the differing strategies they adopted in response to managed care. The diversity of results leads to a reconsideration of the concepts of professional autonomy and ethics. An examination of psychotherapist's life-world suggests that autonomy is relative to the specific practices of managed care review. Formal ethical standards and guidelines may be best understood in relation to psychotherapists' professional ethos and personal values.

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CHAPTER I

INTRODUCTION

Purpose and Trajectory of the Study

Health care services, and mental health care in particular, are becoming increasingly re-organized under what has become generally known as managed care. It is the common wisdom of health care policy experts that managed care, in one form or another, will be with us for the foreseeable future and it is likely to be the dominant mode of organizing health care services. Indeed some estimates suggest that in the near future three quarters of all persons who receive some form of third-party reimbursement for mental health services will be affected by managed care programs (Dorwart, 1990). Managed care has already become a buzzword in a number of areas including major journals sponsored by the mental health professions, specialized interdisciplinary journals devoted to health care policy, workshops sponsored by professional organizations, staff development workshops in community mental health centers, and news stories in mainstream television and newsprint media. Managed care is often

presented as monolithic and looming, especially in the popular media. In actuality it encompasses a diverse set of techniques undertaken by a diverse set of actors to oversee the utilization of health care resources (Dorwart, 1990; Gray & Field, 1989; Tischler, 1990). Managed care is far from a unitary phenomenon.

To put it most simply, managing health care means that third-party payers will act in ways to influence the treatment relationship between a provider and a patient. The stated goal of third-party payers is to achieve efficient and cost-effective health care. As the influence of third-parties on treatment relationships becomes more pronounced and persistent, professional organizations and individual practitioners have raised a number of important concerns about the impact of managed care on the quality of mental health services. This study grows out of a concern over the potentially adverse effects of managed care on the therapeutic relationship as well as on treatment outcomes in psychodynamic psychotherapy. This study utilizes a qualitative-hermeneutic methodology to examine the ways in which psychodynamic psychotherapists experience managed care in a private practice context.

This way of framing the problem is situated in the discursive style of journals and other publications that bridge the fields of mental health and public policy. My original intent in studying the impact of managed care on psychodynamic psychotherapists was to challenge the way expert "bridge" discourses (Fraser, 1989) can act both to disclose and suppress the needs and interests of various parties including clients, therapists, insurers, regulators,

policy experts, and others (Warren, 1991). The original intent of this study was to give voice to the psychodynamic perspective by doing a phenomenology of therapist experiences so as to demonstrate their definition of needs for treatment.

The original intent also was to challenge the apparently exclusive instrumental stance of managed care and to defend the empathic-introspective stance which Kohut (1977) saw as a defining feature of psychoanalysis and depth psychology. It appeared that Habermas's (1987) conception of the ways in which the instrumental orientation of systems act to colonize the lifeworld could be adapted to frame interaction between managed care and the psychoanalytic tradition. At this juncture, however, these initial intentions seem somewhat naive and simplistic. My naive presupposition was that psychodynamic psychotherapists would speak with one voice about the dangers of managed care. When one carefully and systematically attends to what therapists say about managed care, the most striking result is the diversity of what they have to say. Managed care is not a unitary phenomenon and it is also misleading to presume that there is some unifying psychodynamic perspective on this phenomenon.

It is important to reflect on the purpose and trajectory of this study because an essential dimension of my original intention was to demonstrate how a critical hermeneutic approach (Messer, Sass & Woolfolk, 1988) offers the most fitting method for examining the present object of study. A basic meta-theoretical and methodological presupposition was that an interpretive analysis of the relations between knowledge and power is required to disclose

the ways in which managed care could deform an empathic-introspective stance toward the practice of psychotherapy. This meta-theoretical framework combined features of Habermas's version of critical theory and Foucault's post-structuralism. McCarthy (1991) offers a clear analysis of the similarities and differences of these major social theorists and critics and Fraser (1989) has integrated these lines of thought in concrete analyses of power and gender in the modern American welfare state.

Attending to what research participants in the present study had to say, however, entailed a major revisions of my initial commitment to critical hermeneutics. Reflecting on these meta-theoretical frames remains a crucial feature of this study because of the interpretive reflexivity of human existence and understanding (Heidegger, 1962/orig. 1927) and the rigorous examinations of this process of reflexivity in various social science research traditions (Bourdieu, 1992; Pollio, 1982). Part of the continuing purpose of this study is to interweave an analysis of substantive and methodological issues.

The present study, then, is concerned with examining the professional lifeworld of psychodynamic psychotherapists in regard to the impact of managed care. The endeavor begins by asking the following open ended question: "Please think of some times when you have been aware of the impact of managed care on your practice of long-term psychodynamic psychotherapy and please tell me about them." The original research project also included an inquiry into each participant's clinical judgement regarding hypothetical managed care review criteria. The portions of the interviews

related to the question about clinical judgement and practical reasoning have been set aside since they require a different form of analysis than that undertaken in the present study. When participant discussions in response to the first open ended question were analyzed, it became apparent that the social contexts of their professional practice, especially socioeconomic and organizational contexts, were critical to gaining an understanding of the diversity of their experiences of managed care and the ways in which they chose to respond to these experiences. Once a thematic analysis was well under way, it was clear that a major revision of the meta-theoretical framework was needed. The meta-theoretical orientation most fitting to these open ended dialogues about psychotherapist experiences with managed care is an analysis which combines existential-phenomenology with some of the conceptual tools of Bourdieu's (1992) reflexive sociology.

The present study aims, primarily, to articulate lived experience but also to examine the interplay between the "pre-constructed" lived meanings of research participants and the social scientific "re-construction" of the object of study, most broadly defined as the impact of managed care on psychotherapists in independent practice. It is the thematic analysis of research participants' lived experience that raises an objection to many of the taken-for-granted assumptions currently dominating the literature on managed care and mental health policy and service delivery. The possibility of exploring the relationship between pre-constructed lived meanings (dispositions) and re-constructed objective analyses of the structuring of the life-world (spaces of social positions) is presented in the following section and in Chapter IV.

The present study radicalizes Thompson, Locander and Pollio's (1990) claim that "lived experience may not always honor standard conceptual boundaries and, therefore, must be understood relative to the specific life-world from which it emerges (p. 347)." The overall structure of this text follows the standard form of a traditional empirical research study in psychology: introduction, including a background literature review, method, results, and discussion. The textual dynamics internal to each division, however, are somewhat unusual. Each chapter contains a hermeneutic tacking back and forth from part to whole and back again. The thematic analysis of participant experiences shape and drive the construction of this text. The examination of the literature focuses on gaps and disparities in our empirical knowledge of managed care's impact on psychotherapists and their practices.

This strategy of textual construction also follows Bourdieu's analysis and working assumptions about the relationship between theory and empirical investigation in the social sciences. Bourdieu (Bourdieu & Wacquant, 1992) explains that theory

> emerges as a program of perception and action -- a scientific habitus if you wish -- which is disclosed only in the empirical work that actualizes it. It is a temporary construct which takes shape for and by empirical work. Consequently, it has more to gain by confronting new objects than by engaging in theoretical polemics that do little more than fuel a perpetual, self-sustaining, and too often vacuous metadiscourse around concepts treated as intellectual totems. (p. 161)

For Bourdieu, theoretical concepts are both constructed and justified through specific empirical studies. He explains that the concepts he has developed, such as habitus and field, disposition and position

> designate in a kind of shorthand, within the research procedure, a theoretical stance, a principle of methodological choice, negative as well as positive. Systematization necessarily comes ex post, as fruitful analogies emerge little by little, as the useful properties of the concept are successfully tried and tested." (Bourdieu & Wacquant, 1992, p. 161)

Although the textual construction of this study may be unusual, its present goal is more modest in comparison to the original critical hermeneutic intent. This study will attempt to provide a snapshot of a field of professional activity that is currently in a state of flux. Participant concerns were mainly focused on how their clinical autonomy and monetary relationship with patients are undergoing change. The tension between professional ethos and economic needs and interests (Burstein, Miller & Warren, 1984) appears to be a greater current concern than any danger posed to psychoanalytic or psychodynamic theory and technique.

While undertaking this study and constructing this text, I have been torn between three different audiences or constituencies: exisitential-phenomenolgists; psychotherapists in the private and public sectors, especially psychodynamic psychotherapists; and policy and decision-makers in the mental health system. It is the actions of the latter group who shape the contexts of action, the day to day choices and limitations of psychotherapists and their patients. Perhaps the best that can be hoped for is that the present method of inquiry will engage the various audiences in some effort to understand and accommodate to one another's needs and interests. The basic challenge is to show how existential-phenomenology articulates needs and interests in a new light, and opens up additional pragmatic possibilities.

Existential-phenomenology and Reflexive Social Science

In this section I examine in greater detail the meta-theoretical approach that structures this study. A brief overview and commentary on the development of an existential-phenomenological paradigm for psychology is presented first. This discussion is restricted to developments on the American scene. The discussion then turns to exploring the ways that concepts derived from hermeneutics and relexive sociology are usefully employed in an analysis of the impact of managed care on psychodynamic psychotherapists.

Since the 1970s existential-phenomenology has been emerging as a significant alternative within psychology (Giorgi 1970; Pollio 1982; Valle and King 1978). Continental philosophy, especially in the work of Heidegger (1962/orig. 1927), Sartre (1962/orig. 1943) and Merleau-Ponty (1962/orig. 1945), has played a crucial role in the development of existential-phenomenology as a distinctive paradigm in psychology. Gestalt psychology also has made important contributions to the development of the exitential-phenomenological paradigm in psychology. Existential-phenomenology recasts psychology as a human science and gives priority to first-person descriptions of experience.

Beginning in the 1980s, psychologists influenced by phenomenology, social constructivism and, more broadly speaking, the humanistic tradition became interested in hermeneutics as a meta-theoretical framework for understanding and justifying their scholarly activities. Hermeneutics is generally defined as the art and science of interpretation. This hermeneutic

turn was influenced, again, by developments in European philosophy and social science. For example, two hermeneutic philosophers, Ricoeur (1976 & 1981) and Gadamer (1975), who have had a considerable influence on the development of hermeneutic framework in psychology, use Hediegger's existential ontology as a point of departure for the own work. Packer (1985) used Heidegger's ontology to compare a hermeneutic paradigm with the raionalist and empiricist paradigms in psychology.

Messer, Sass & Woolfolk's (1988) edited volume, based on a symposium held at Rutgers University and sponsored by the Graduate School of Applied and Professional Psychology, explored the various approaches gathered under the rubric of hermeneutics. They divided hermeneutics into three facets: methodological, ontological, and critical. Their manner of drawing out the relevance of hermeneutics for psychology emphasizes the inclusiveness of a diverse set of theoretical and epistemological approaches that share a common commitment to the primacy of the interpretive effort.

Messer, Sass & Woolfolk's (1988) introduce and describe the methodological facet as follows:

> The hermeneutic approach insists upon the inseparability of fact and value, detail and context, and observation and theory. It seeks less to generate universal laws than to understand the specific case in its historical and cultural context. Methodological hermeneutics utilizes qualitative description, analogical understanding, and narrative modes of exposition. It deemphasises quantification and controlled experimentation, and does not seek a neutral, objective vocabulary with which to characterize social phenomena (p. xiv).

Ontological hermeneutics contends that interpretation is a fundamental feature of human existence. We exist through our constant and

ongoing engagement in unreflective and reflective acts of interpretation. This interpreting activity is guided by practical concerns. The upshot of ontological hermeneutics is that the "inseparability" of theory/observation and fact/value is an existential condition and not an only an epistemological claim of late modern or postmodern science.

Critical hermeneutics, as Messer, Sass & Woolfolk (1988), point out incorporates the insights of the other "branches" of hermeneutics. They state that the goal of critical hermeneutics is the analysis of "the moral and ideological underpinnings of intellectual practices and social institutions, in order to foster emancipation from arbitrary forms of cultural and political domination" (Messer, Sass & Woolfolk, 1988, p. xiv). They identify critical hermeneutics with the neo-Marxist Frankfurt school and with Habermas, although this branch of hermenutics may be defined, more comprehensively, as an examination of the relationship between forms of knowledge (interpreting activity) and power.

Any of these "facets" of hermeneutics may be emphasized to the exclusion of the others or some of these features may be integrated in complex ways. The approach that I am developing here integrates important features of each "facet" of hermeneutics. An emancipatory intent -- itself freed of the constraints of ideological analysis -- is founded within an ontology of being-in-the world. This intent guides the proposed synthesis of subjective description and narrative exposition of methodological hermeneutics with the objective description of social positions.

Within the discipline of psychology, the scientific object of existential-

hermeneutic phenomenology is the constitution the lifeworld. The basic working assumptions of this paradigm for psychology are clearly and succinctly stated as follows:

> The research focus is on experience as described from a first-person view. The research logic is apodictic, meaning that researchers seek to apprehend meaning as it emerges (Husserl, 1960/orig. 1925). The research strategy is holistic and seeks to relate descriptions of specific experiences to each other and to the overall context of the lifeworld. The research goal is to give a thematic description of experience (Thompson, Locander & Pollio, 1989, p. 137).

When psychotherapists describe their first person experience of managed care they embed their personal experiences and concerns in a variety of social contexts. Thus, from the perspective of existential-phenomenological psychology, it is not appropriate "to study individuals separate from the environment in which they live or the interaction of the two (which implies separation)" (Thompson, Locander & Pollio, 1989, p. 135). The commitment to an ontology of being-in-the-world means that the personal and social are two facets of experience that stand in a figure/ground relation to one another.

Existential-phenomenology is not restricted to one methodological form. Pollio (1991a) explains that various methods are used in empirical phenomenological studies which include: open-ended interviews, analysis of pre-existing texts, questionnaires and written descriptions of experience, thought sampling, and behavioral sampling and observation. These empirical phenomenological methods share a conceptual and pragmatic family resemblance and are gathered together by their capacity to disclose thematic structures of the life-world. Existential-phenomenology tries not to

throw away potentially useful empirical tools.

The present research participants' focal experiences and concerns appear to be specifically related to different organizational forms of managed care and to different managed care review processes. Given the embeddedness of their experiences in different socio-economic contexts of practice, it is helpful to explore the contributions of existential-phenomenological sociology. The basic claim of existential-phenomenological sociology is that experience is constituted through the ongoing embodiment of socio-historical conditions (Ostrow, 1990).

As previously noted, Bourdieu's work appears to be especially relevant and useful, but a certain reading of it is required to render it compatible with existential-phenomenology. Although Bourdieu's work is influenced by Husserl, Heidegger and Merleau-Ponty, he appears to adopt an ambivalent attitude toward phenomenology (Ostrow, 1981 & 1990). His conceptual tools originate from the French structuralist tradition. While Ostrow (1981) argues that "Bourdieu is hardly a phenomenologist, minimally concerned with the experiential dynamics of human embodiment, he has still centered social theory in a phenomenological recognition of pre-reflective, funded meaning" (p. 282). Clearly, Bourdieu's work breaks with a number of "false antinomies": the ontological separation of the subjective and objective modes of knowledge; the separation of theoretical reflection from methodological procedures in the actual practice of research; and, within the specific purview of sociological theory, the separation of macro and micro levels of analysis (Wacquant, 1992). Existential-phenomenology also shares

in the rejection of these antinomies.

Wacquant (1992) explains that Bourdieu's work incorporates subjective and objective methods as two moments in a single intellectual enterprise:

> The resulting social praxeology weaves together a "structuralist" and a "constructivist" approach. First, we push aside mundane representations to construct the objective structures (spaces of positions), the distribution of socially efficient resources that define the external constraints bearing on interactions and representations. Second, we reintroduce the immediate, lived experience of agents in order to explicate the categories of perception and appreciation (dispositions) that structure their action from the inside. It should be stressed that, although the two moments of analysis are equally necessary, they are not equal: epistemological priority is granted to objectivist rupture over subjectivist understanding. (p. 11)

Research on managed care and mental health services may benefit greatly from this conceptual framework, and the approach I am taking in the present study is designed to initiate such a course of research. Since my own approach is rooted in ontological and critical hermeneutics, the epistemological priorities are reversed: lived experience has the first and last word. Nevertheless, objective "moments" of distantiation, whether they be mediated through structuralist methods (Ricoeur, 1981) or through quantitative statistical methods, play an important role in understanding and explaining the constitution of individual experience and the life-world.

Several of Bourdieu's main concepts have an important application to the present study. These concepts are: disposition, habitus, position, field, and capital. Disposition refers to the regular pattern of "perception and apperception" of individual agents. This concept highlights the unity of our

capacities for cognitive appraisal and assignment of value. Bourdieu's concept of habitus is used to patterns of individual and collective disposition. Habitus reflects enduring ways of adjustmenting to the practical demands of the social world. While habitus may refer to actions undertaken with a strategic interest, habitus is typically the unreflected ground of our activities. Habitus may strategically guide action without conscious deliberate choice.

Ostrow (1981) provides an existential-phenomenological reading of habitus:

> Habitus establishes culture, beyond its purely visible contours, as a phenomenal field of experience by saturating individuals in a shared world with its established networks of practice....If, on the deepest levels of experience, the silent workings of habitus constitute's the subjects practical position in the world, then our task is to locate the phenomenological contours of how this pre-conscious posture of being situated forms at once the pretext and context for perception and conduct. (p. 289)

Positions are places within objective social space that confer certain freedoms or limits upon action. Objective social spaces are determined through empirical procedures. The most typical quantitative method employed by Bourdieu for this purpose is correspondence analysis, a multivariate descriptive statistic. An analysis of this type clusters individuals according to their associations on various properties. These quantitative methods were used in the studies assessing dimensions of status and power in the academic field (Bourdieu, 1984).

Bourdieu (1992) explains that the concept of field is more comprehensive than that of position:

> In analytic terms, a field may be defined as a network, or configuration, of objective relations between positions. These

> positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation (situs) in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology, etc.). (p.97)

Finally, the concept of capital is relevant because it brings into play what struggles within a field are all about. One of Bourdieu's conceptual innovations is a freeing of the idea of capital from its moorings to the dominant modern world view of "Man" as an economic animal. In addition to the typical form of capital as economic resource, Bourdieu investigates social capital defined as "the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual recognition" (Bourdieu & Wacquant, 1992, p. 119). More comprehensive than economic or social capital is symbolic capital, which refers to "the form of that one or another of these species [economic, cultural, and social capital] takes when it is grasped through categories of perception that recognize its specific logic or, if you prefer, misrecognize the arbitrariness of its possession and accumulation" (Bourdieu & Wacquant, 1992, p. 119).

Re-phrasing this in existential-phenomenological terms, symbolic capital refers to relatively formal and institutionally embodied patterns of interpretation that endure through relations of power. The disciplines of the social sciences are themselves a major field in which symbolic capital is contested. The discourse on managed care within professional journals, as well as in more mundane discourse such as day to day phone calls between

psychotherapists and managed care reviewers are both, in part, struggles for symbolic capital.

The most direct application of these concepts to the ways in which research participants in this study spoke about their experience with managed care is to consider the relationship between the habitus of these participants and the changing structure of the field of mental health services. I believe Bourdieu puts the matter of the good or poor fit between habitus and field quite clearly and poignantly when he says that in times of rapid social change or revolution:

> changes in objective structures are so swift that agents whose mental structures have been molded by these prior structures become obsolete and act inopportunely (a contre-temps) and at cross purposes; they think in a void so to speak, in the manner of those older people whom we may justly say they are "out of synch." In short, the ongoing dialectic of subjective hopes and objective chances, which is at work throughout the social world, can yield a variety of outcomes ranging for perfect mutual fit (when people come to desire that to which they are objectively destined) to radical disjunction (as with the Don Quixote effect dear to Marx). (Bourdieu & Wacquant, 1992, p. 130)

The phenomenological analysis of psychodynamic psychotherapists' experience of managed care yields a diverse set of experiences. Many were negative, some extremely so; but some were quite positive and attested to a comfortable sense of fit with the changing structure of the field of mental health services. An analysis of the ways in which research participants chose to respond to managed care will be presented in the final chapter. The next section examines the field of mental health services.

Managed Care and Psychotherapy

In this section I will attempt to describe the current state of managed care and psychotherapy services providing background information as it pertains to the context of practice of the types of research participants in this study -- managed care of psychotherapists in independent practice. Mental health services in the private and public sectors and the structures for funding those services are undergoing a rapid evolution, if not revolution.

This section involves a background "literature review" that is oriented to clarifying the ways that these research participants speak about managed care. There are several difficulties one encounters when attempting to evaluate the scientific and professional literature on managed care in order to translate what is reported as objective conditions into a contextual ground for lived experience. For example, (Shadie & Christianson (1988) surveyed Health Maintenance Organizations (HMOs) and reported indices such as percentages for staffing patterns, use of contracts with psychotherapists in independent practice and types of services offered in different HMO models. This type of data reporting does not provide a sense of how organizational and economic structures affect the actual practices of psychotherapists in these systems.

Part of the reasoning for structuring background information in this manner is that the formal research and policy literature is itself contradictory and incomplete. This appears to be the case when one examines reports on HMOs (Cheifitz & Salloway, 1984) and the evolving utilization management industry (Gray & Field, 1989). The latter industry

includes independent companies solely concerned with contracting utilization review and case management services to third-party insurers. The incompleteness of the information on managed care becomes more apparent when examined from the perspective of determining a meaningful social field of mental health constituted from the perspective of psychotherapists in independent practice. In other words, it appears that there are few reliable guides at hand that evaluate the way specific organizational forms of managed care (i.e. a specific Health Maintenance Organization or utilization review company) actually operate in their day to day practices. Some of the sources that have the most timely and pertinent information that enables one to situate managed care in the psychotherapists life-world come from sources such as trade journals (e.g. Behavior Today).

Speaking about managed care as a unitary entity seems unavoidable. In the literature it is often described as an umbrella term but it is one which is then discussed with few discriminations even after the term is acknowledged to be heterogeneous. At this point, I can see no other way to proceed myself. Hopefully, this section should provide a recognition of the diversity of the forms of managed care and this diversity can be kept in mind whenever the shorthand term "managed care" is used.

The research participants in this study also speak about managed care as if it were a unitary phenomena; some even personify the term. Their definitions of managed care do not coincide with those used in the literature. One participant began the interview by defining utilization review and then defining managed care in order to contrast the two terms. S/he defined

"managed care" as a set of case management services which flexibly adapt third-party reimbursement to an individual patient's needs. This particpant's description of case management is consistent with the description of case management in the literature but her/his general definition of the term "managed care" was somewhat inconsistent with its use in the literature. Similar inconsistencies were evident in other participant interviews.

Managed care can refer to any form of review by a party external to the provider-patient relationship that aims to restrict utilization or modify the specific type and extent of services that are utilized, including selection of specific providers (Broskowski, 1991; Gray, & Field 1989; Tischler, 1990b). Many entities that would be considered "managed care" are companies who do not share any indemnity risk but contract out utilization review and case management services to third-party payers, including government, private insurance companies and businesses that are self-insured.

Actually managed care has existed, in a significant form, since the 1970s when federal legislation created Health Maintenance Organizations (DeLeon, VandenBos, & Bulato, 1991). Subscribers to HMOs are increasing as a percentage of persons who have private health insurance in the United States. The total enrollment for HMOs is over 35% of the privately insured population. Interestingly, the two states from which I have drawn participants for this study fall at opposite ends of the spectrum of market penetration by HMOs. Massachusetts has more than 20% of its population enrolled in HMOs while Tennessee has less than 5% ("Bush policies and

I.R.S. at odds over health care", February 9, 1992). Mental health services, in general, appear to be much more affected by managed care than those in Tennessee. Massachusetts is the first state in the nation to obtain a waiver from the federal government to turn the entire state medicaid mental health and substance abuse services over to a private national managed care company. An unexpected irony is that this private national managed care company is headquartered in Tennessee.

There are several good reviews on how psychotherapy has evolved with HMOs (Austad & Berman, 1991; Shadie and Christianson, 1988). The quality of care of mental health services within HMOs remains controversial. Austad & Berman (1991) have taken a laudatory view of HMO psychotherapy services, while Frank and Dubin (1991) have felt that the emphasis on cost-containment in HMOs has eroded the quality of psychiatric care.

Some brief clarifying comments about the organizational classification of third-party coverage are needed. Private third-party reimbursement of healthcare services has been typically divided between traditional indemnity plans and HMOs. The HMOs have been further subdivided into staff model plans and Independent Practice Association Plans (HMO/IPAs). Most HMO plans are financed through prospective payments (or capitation). When a subscriber to an HMO staff model seeks psychotherapy, they are directed to salaried staff and cannot be reimbursed to see psychotherapists in independent practice.

Traditional indemnity plans have typically provided inpatient and outpatient mental health coverage with a annual cap on the dollar amount

for each of these services. These insurance plans typically involve a deductible or co-payment for the subscriber. Under this form of third-party reimbursement, the patient is free to choose any mental health care provider and the provider is reimbursed on a unit rate for each unit of service (fee-for-service). It is now becoming more common for traditional indemnity plans to contract with another organization to perform utilization review of its fee-for-service mental health benefit. This utilization review is a form of managed care because the review process may entail various limitations on benefits. Traditional indemnity plans also are reducing their costs by limiting the pool of providers who are eligible to participate in their insurance plan. These organizational forms are called Preferred Provider Organizations and contracts are set up with independent practioners which involve discounted fees and various managed care review mechanisms.

Literature reviews of mental health services are quickly becoming out of date as various organizational forms and financing mechanisms become blurred together. It is impossible to tell how a mental health benefit plan will work in practice by looking at its categorical classification as indemnity insurance, HMO staff model, HMO/IPA or PPO. Virtually all of these organizational forms now incorporate some form of managed care in terms of pre-certification, concurrent review and/or specific treatment protocols.

It is a commonplace observation to say that this is all driven by excessive and out of control health care costs. Castro (1991) writing in Time magazine reports that "Americans spend $23,000 a second on medical care, more than $2 billion a day, $733 billion a year" (p. 34). During the past two

years the rate of inflation for health care services has been at about 10%, nearly double the rate of inflation for general goods and services. A major concern of large corporations is that the escalating cost of health care drives up labor costs at a time of low productivity. The feared result is declining strength and competitiveness relative to other advanced industrialized countries in the global economy (Broskowski, 1991; Castro, 1991). Recently, health care costs have been found to take 26% of corporate net earnings.

This news has been picked up by Behavior Today, a trade journal for mental health professionals, and transmitted with an alarming tone:

> Increasingly, employers will turn away from traditional, fee-for service programs, and look to cost-containment strategies such as utilization review and managed care. Mental health services are viewed as "elective" and are among the first to be limited or eliminated. Providers unwilling to package their services through such structures as HMOs, PPOs, and Employee Assistance Programs will find themselves competing for an increasing smaller share of the market" ("Health Economics," February 18, 1991)

The article continues to recommend that providers "strategically" market their services in ways that demonstrate an ability to reduce the utilization of health care services.

In 1987 Behavior Today conducted a survey of its readers about changes occurring in the mental health system involving managed care services (HMOs/IPAs/PPOs). The results showed that 43% had direct experience with these services. 86% of the respondents felt that managed care would result in poor quality of care ("BT survey results," July 20, 1987). Half of the respondents said they would not participate in managed mental health services. Almost four out of five respondents felt that limitations

would be placed on the number of sessions per patient. A number of other disadvantages concerning participating in a managed care system were reported: increased paperwork (67% of the respondents), use of gatekeepers(55%); decreased flexibility in treatment approaches (47%), long waiting time for reimbursement (46%), and increased competition (23%). Respondents also identified the following advantages of joining a managed care system: "increased client flow (36% of the respondents), less marketing effort on the part of providers (32%), stability in a changing marketplace (25%), increased income/cash flow (20%) ("BT survey results, July 27,1987).

Approximately four years later the picture had changed considerably. After attending a forum of mental health care providers, third-party purchasers, and managed care companies, 1991 Behavior Today emphasized the positive features of joining a managed mental health care organization or network. They reported that many psychotherapists at that forum claimed there was greater consistency in cash flow reported when affiliating with a managed care network. The emphasis in the report fell on the identification of ways to enter a managed care system. It was noted that there were no reliable directories for EPAs HMOs or PPOs and independent psychotherapists were usually left on their own when finding out how to join a network.("Entering a managed care network", September 30, 1991). There has been a notable change in concern in that trade journal: rather than resisting managed care, mental health professionals appear to be advised to fight to get on the train before it leaves the station.

A Model for Professional Autonomy: Clinical Autonomy and Authority

The concept of professional autonomy is one that is becoming increasingly significant in the context of the re-organization of health care services in the United States. Professional autonomy is a central issue for policy makers, researchers and others concerned with the comparative politics of health care among advanced industrialized nations (Freddi & Bjorkman, 1989). Autonomy also appears to be a significant existential-structural feature of the life-world of psychotherapists in this study. This section presents a model for professional autonomy oriented to clinical autonomy that allows us to examine the issue of clinical autonomy of psychotherapists in different mental health service delivery systems.

First of all, it is useful to briefly review some of the current meanings and uses of the term "profession". Torstendahl (1990) argues that a thorough study of professions involves three approaches: an analysis of the properties which distinguish professions from other social groups and provide a schema for classification; the identification of interests and strategies of professional groups as they compete with other social groups; and an historical account of the development of professions. He claims that these approaches are not mutually exclusive and that the study of professions is best accomplished when their structural and functional features are embedded in socio-historical analyses.

Burstein, Miller and Warren (1984) point out that the concept of profession has a variety of meanings that only partially overlap.

Historically, the noun "profession" signified the act of taking

> vows of a religious community; then an act of publicly claiming a belief, faith, or opinion; later an avowed religious faith; and most recently, a calling that involves specialized knowledge (Woolf, 1973). This drift of meaning reflects the close relationship between professionalism in the most contemporary vocational sense and beliefs governing personal behavior - morals and ethics. (Burstein, Miller & Warren, 1984, p. 41)

Professions are distinguished by their ability to secure relatively closed markets for highly specialized services and then control these markets through their own self-regulation (Collins, 1989). Freddi (1989) sums up these observations about current professions and explains that self-regulation in conjunction with codes of ethics provide the basis for the social legitimation of these closed markets:

> An occupation evolves into a community of professionals when, in the practice of that occupation, decisions are based on an esoteric, academic, highly technical knowledge and on a common ethic which stresses both the interests of clients and a service orientation. Moreover, the professional community indemnifies the public by controlling the recruitment, selection, and training of its members, and by exercising disciplinary power over those members who trespass the boundaries of legitimate and technically warranted professional action. (Freddi, 1989, p. 4)

These feature do not automatically guarantee that a profession will have autonomy. Autonomy is a relative state, a relational condition between the profession and other social groups. The legal and economic aspects of professional autonomy are granted by the state although the autonomy of individual professionals is embodied through wide-ranging social norms and interactions.

Freddi's (1989) cross-national examination of the autonomy of physicians suggests four useful analytic dimensions with which to assess the degree of professional autonomy: (1) <u>remuneration</u> - the degree to which

doctors freely determine their fees directly with their patients on a fee-for-service basis; (2) clinical autonomy - the degree to which individual doctors determine diagnostic and therapeutic procedures without any external interference; (3) leadership - the degree to which doctors lead and direct the actions of other health care professionals; and (4) control of the profession - the degree to which doctors determine professional issues (e.g., standards of care, professional ethics, etc.) through decision making internal to the profession.

Freddi argues that the institutional complexity of health care services as well as increasing budgetary constraints in public and private sectors raise significant questions about received visions of professional autonomy. In many ways, the social construct of an "independent practicer" is a thing of the past. Freddi states that the important "problem confronting us is that of determining which type of organizational rationality is more hospitable to the requisites of medical decisions and work processes" (Freddi, 1989, p.23).

Of the four dimensions of profession noted above, the most relevant dimension for the present study concerns clinical autonomy. Although of these dimensions each was touched on in the participant descriptions of their experience, they were mainly concerned with the ways in which managed care affected day to day practices with their patients and their patients' ability and desire to remain in treatment. To a lesser extent, they raised concerns about the ability of professional organizations to defend their interests.

Dohler (1989) and Harrison and Schultz (1989) point out that the

degree of clinical autonomy of the individual clinician does not correlate with macro political-economic structures. Countries with market dominated health care systems, like the United States, show an increasing trend toward restriction of clinical autonomy whereas European countries with national health services and /or global national budgets for health care expenditures have, on the whole, retained greater clinical autonomy for the individual clinician.

Beckman's (1990) model of professional authority appears to provide a useful conceptual way of examining the relationship of managed care organizations (and their review processes) to psychotherapists in independent practice with respect to the question of clinical autonomy. This model is presented in Figure 1, and has been adapted to locate the relative position of managed care reviewers and psychotherapists in independent practice.

Beckman's model is based on a taxonomic approach to the study of professions. He focuses on the ability of professionals to accrue and maintain social authority; that is to secure the voluntary compliance of others. He defines professionalization as "an increase in the relative importance of socially sanctioned expertise in the authorization of social interaction in general and of work relations in particular (p. 115). Beckman situates professional authority in a "borderline" region between the expert authority of any individual person who has acquired specialized knowledge and technical skill and the bureaucratic authority of institutions. Both of these forms of social authority share a common intentionality of structuring social

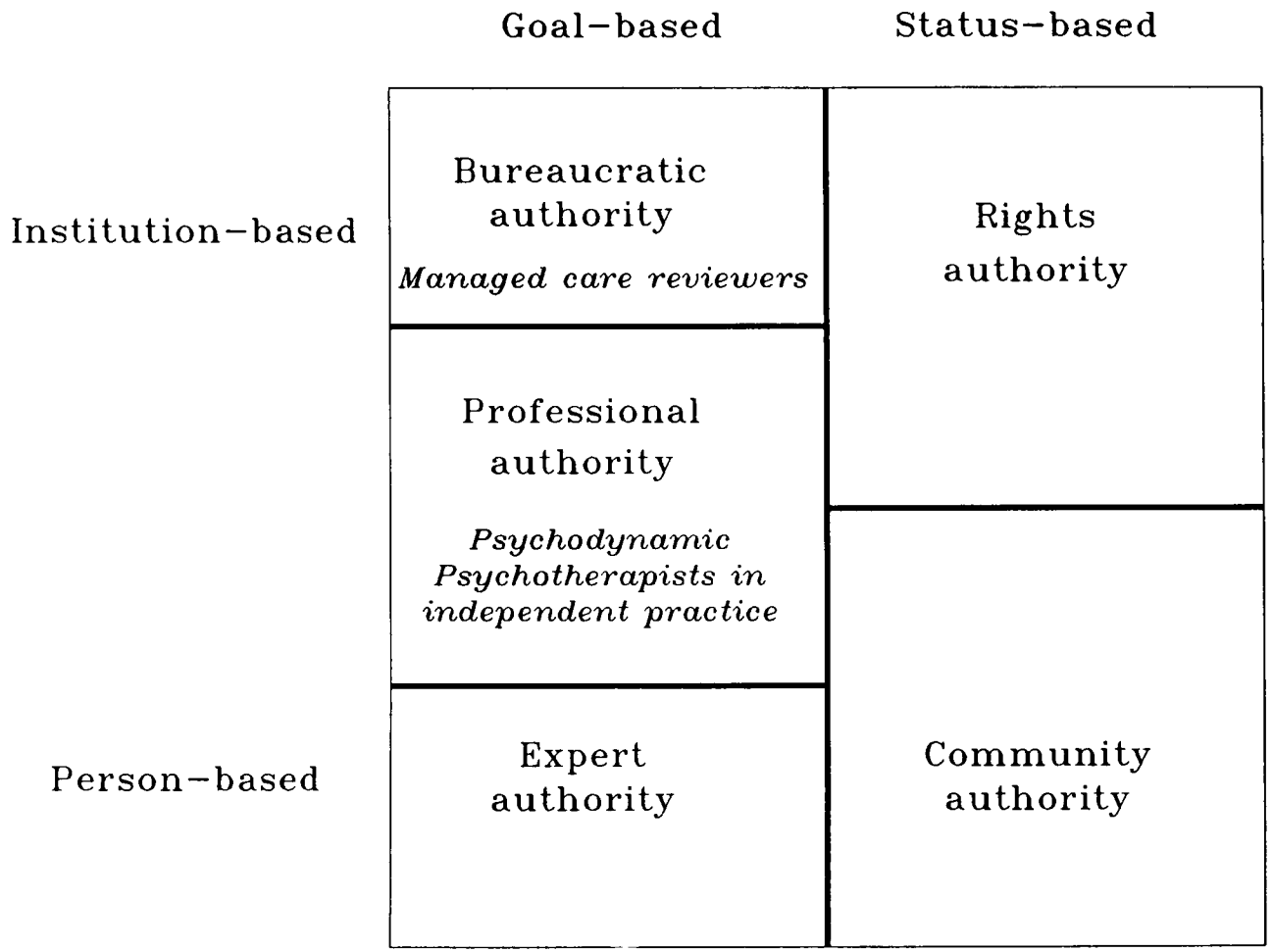


Figure 1. Adapted from Beckman, S. Professionalization: Borderline authority and autonomy in work. (1990). In M. Burrage & R. Torstendahl (Eds.) Professions in theory and history. London: Sage

action on the basis of goal achievement. When an individual professional is engaged in action, one or all of these forms of authority may become relevant to that particular context of action.

This model provides a ground for understanding "the competitive efficiency of professional authority when clashing with instructions given by agents of other types of authority" (Beckman, 1990, p. 135). In other words, this model lays out the battle ground on which struggles over clinical autonomy are occurring. Managed care operates within the sphere of bureaucratic organizations and its review processes exercise bureaucratic authority. Managed care also interpenetrates the professional sphere.

As Beckman explains, bureaucratization and professionalization are not necessarily mutually exclusive social spaces:

> While for a long time professions have tended to lose formal legal autonomy on Western work markets by becoming employed in private and public bureaucracies, it is, by this fact alone, far from clear that professional authority has lost its relative importance. The exercise of expert authority is not directly dependent on such formal conditions. On the other hand, members of groups with the typical academic credentials of a profession, like civil engineers, may only marginally exercise professional autonomy in their work, while predominantly exercising bureaucratic authority due to management positions. (Beckman, 1990, p.135)

Thus, the formal organizational structure in which psychotherapy is conducted does not necessarily tell us how freely individual psychotherapists exercise clinical autonomy. From an existential-phenomenological perspective, the modeling of a region of professional authority carves out a meaningful social space within the life-world. This model may be used to provide a context for understanding the co-constitution of managed care

practices as well as of psychotherapist experiences. When this model is taken, instead, as scientific object, it allows us to re-construct the present research participants' lived experience of managed care in terms of conceptual frames utilized by mental health system decision-makers. The reconsideration of this model is presented in the final chapter in order to assess the strategies that psychotherapists adopt toward managed care.

CHAPTER II

METHODS

Hermeneutic Procedures

A qualitative method is adopted for this study that is informed by a particular research group (Barrell, 1987; Dapkus, 1983; Hawthorne, 1988; McGillevray, 1985) working within the family of empirical methods in psychology informed by existential-phenomenology (Collazzi, 1978; Pollio, 1991a, 1991b;). The specific hermeneutic procedures that I have adopted emphasizes the researcher's own interpretative re-construction of meaningful texts (Packer, 1985; Shell, 1986). This approach emphasizes the criteria of narrative coherence in the construction of meaningful interpretations of a text (Ricoueur, 1981). This emphasis on narrative coherence also draws on Mishler's (1984; 1986) work on research interviewing. The specific procedures that I have adopted for this study, owing to their closeness to the critical hermeneutic tradition, stress the researcher's re-construction of meaning (McCarthy, 1991).

Contrasting studies within existential-phenomenology are those that focus on a fundamental existential dimension such as time (Dapkus, 1983) or on a specific way of being-in-the-world such as being alone (Barrell, 1987). Those studies give relatively greater weight to reliable verification of an existential thematic structure across participants. The present study aims,

instead, to disclose an ongoing process of coherent practical activity (the independent practice of psychodynamic psychotherapy) as it occurs against the ground of a changing social landscape (managed care). The existential thematic structure in the present study provides the context out of which emerges the differential set of dispositions and strategies that psychotherapists can take up in response to managed care.

The hermeneutic procedures that I am working with have been carefully described by Pollio (1991b) and Thompson, Locander and Pollio (1989). The general method will be briefly reviewed in the remainder of this section. The points where I diverge from this general method will be discussed in the subsequent sections in this chapter. Pollio (1981b) demonstrates that the hermeneutic approach is well-suited to examining experts' self-understanding of their practical activity. He explains that a basic working assumption of this method is that in order to understand an expert experiences:

> it is necessary to interview them in such a way as to let them tell us what we need to know rather than to ask them what we think, a priori, we would like to know. (p. 4)

A phenomenological interview is conducted in an open ended manner and the researcher's task is to use clarifying questions and/or statements that allow the participant to speak about what is most salient and relevant in his or her experience. Nevertheless, it is inevitable that the interviewer's presuppositions will also shape the interview since they are a partner in the dialogue (Mishler, 1986; Pollio, 1991b; Thompson, Locander and Pollio, 1989). A recent methodological innovation involves a "bracketing interview" in

which the interviewer is interviewed about his/her presuppositions and goals concerning the research question. The intended practical effect of this procedure is to allow the research participant to take the lead in the interview. This hopefully enables the researcher to remain open to unexpected topics and turns in the conversation as well as to views that may conflict with personal expectations.

The interviews are typically audio-taped and later transcribed into a written form. At this point, the meanings that were at play in the spoken face-to-face encounter are fixed in the form of a text. It is this fixation of meaning that allows an intersubjective set of interpretive procedures to be employed in the form of a human science (Ricoeur, 1981a). The researcher, then, typically proceeds with a series of independent thematic analyses of the texts and presentations of the texts and the thematic analyses to the interpretive group. The interpretive group consists of other researchers who are familiar with such hermeneutic procedures.

The researcher will make one or more presentations to the interpretive group in the course of analyzing the texts. These presentations to an interpretive group may assist the researcher in all tasks and phases of the analysis. The analytic tasks include: bracketing presuppositions, commenting on the conduct of the interview, questioning specific interpretations of the text, relating interpretations of specific parts of a text to other parts of the same or different texts in order to articulate common experiential themes, and evaluating the overall configuration of the resulting thematic analysis. The common patterns of meaning across all texts that

emerge from this process are called themes. The goal of the entire process is to articulate a pattern of themes that provides a comprehensive description of the experience or situation is being investigated.

Researcher's Presuppositions

As phenomenological methods have been influenced by ontological and critical hermeneutics, researchers have recognized that it is impossible to escape (or "bracket") all of one's presuppositions. The task, instead, is systematically to render them explicit to the extent that this is possible and, then, to incorporate an awareness of such presuppositions into the entire research process. Many recent existential-phenomenological studies have accomplished this through "braketing interviews" conducted with the researcher prior to the interviewing phase of the study (Pollio, 1991b; Thompson, Locander and Pollio, 1989).

I did not participate in a formal "bracketing" interview but the purpose of such an interview was served through several presentations of pilot interviews to the interpretive group. The formulation of the final set of interview questions used in this study took place over the course of a year. During this time, the inquiry shifted from an examination of limitations placed on long-term psychotherapy in public sector mental health services in Massachusetts to a broader investigation of the impact of managed care on psychotherapists providing long-term psychotherapy in an independent practice setting.

The selection and modification of the topic of study has remained

quite revealing. There is no doubt that my own personality, working class origins and current position, and conflicted allegiance to the working class inform the presuppositions (or set of dispositions) that shape and motivate this study. The specifically personal dimensions to this set of dispositions do not fall within the scope of the present text. Nevertheless, these personal dimensions have been a constant point of reference that I have tried to examine while undertaking this study. The availability of economic, social and cultural capital have obviously affected the process of carrying out this study. The concepts of disposition and position are useful tools for analyzing my presuppositions at both stages of the development of this study. These tools are applied retrospectively since I did not employ them while I was developing the research questions. I only brought them to bear on the organization of this text after nearly completing the data analysis.

What appears to have motivated the choice of the original topic of study was a number of experiences as an employee in a private vendor agencies supplying mental health services to the persons whose care was subsidized by the state of Massachusetts. I clearly identified with the social position of persons in those service systems who needed long-term psychotherapy but were ineligible for such services. Just as important, the set of dispositions -- the professional ethos -- that I had developed through my graduate training did not fit with the policy and administrative priorities and practices of those organizations. These experiences shaped the origin of this study and its eventual re-direction to the question of managed care and the private practice context.

Selection and Description of Participants

Using an existential-phenomenological research method to study how psychotherapists experience managed care entailed the following commitments for selecting research participants for this study. Participants should have experiences relevant to the object of study and be capable of reflecting and describing their experiences. Research participants for this study were selected on the basis of specific identifiable characteristics. They described themselves as having a psychodynamic theoretical orientation and on conducting psychodynamic psychotherapy in a private (or independent) practice setting. They also indicated that they had experienced some effects of managed care on their practice and had thought about these experiences and issues. Participants were selected for inclusion in the study based on personal and/or professional acquaintance.

The participants could be from any mental health profession but they should be licensed and conducting psychotherapy either full-time or part-time in independent practice. The only specific characteristics used to select participants was geographic location, the community in which they were practicing. This characteristic was used to "sample" from two different "populations" because of my own acquaintance with the different socioeconomic and organizational contexts of practice. Five participants were selected from the Boston metropolitan area and five form the Knoxville metropolitan area. This subject selection procedure was clearly not random but was designed to select participants who were in a an objective position and had a subjective capacity to articulate a range of experiences within the

relevant life-world that was being explored.

Table 1 describes the characteristics of participants included in the present study. At every step of the process, care has been taken to assure the anonymity of these participants. Special care is required in the present study because of the relatively small and dense professional communities in which participants live and practice, so any potentially identifying data will be presented in aggregate form.

Interview Process

Letters were sent to prospective participants to solicit involvement, provide information on the purpose and design of the research, and explain their responsibilities as participants. These letters were followed by a telephone contact and a face-to-face interview was arranged. These interviews took approximately one hour. All interviews were audio-taped and transcribed with the assistance of a transcriptionist. The interview was conducted in an open-ended manner in which the research participant was free to explore any experience or issue after each of the following two questions were asked:

> Question #1. Please think of some times when you have been aware of the impact of managed care (or utilization management) on your practice of long-term psychodynamic psychotherapy. Please tell me about them.
>
> Question #2. Could you tell me about a case that would be likely to need and benefit from long-term psychodynamic psychotherapy but would not be eligible for this treatment according to the analogue managed care criteria that you have been given? Please discuss the relevant diagnostic and functional criteria and psychodynamic processes without revealing information that could identify individuals.

Table 1. Descriptive characteristics of research participants.

Gender	Female	Male
	5	5
Geographic location	Tennessee	Massachusetts
	5	5
Professional discipline		
Ph.D. Psychologist	7	
Psy.D. Psychologist	1	
M.D. Psychiatrist	1	
M.S.W.	1	
Types of current employment		
Private practice psychotherapy		
	Full-time	Part-time
	6	4
University/Medical or professional school		
	Full-time	Part-time
	3	
Hospital services (inpatient, residential, outpatient)		
	Full-time	Part-time
	1	2

The participant was given these questions prior to the interview as part of the informed consent process. After the research participant and the interviewer were satisfied that the first question had been adequately explored the second question was presented and a dialogue about it ensued. As noted in Chapter I, only the first question is analyzed in the present study; sections of the interviews pertaining to the second question have been set aside for analysis in a separate study.

Text Analysis

There are moments of insight in all scientific activity but, when it comes right down to it, there is actually little mystery in hermeneutic research. The procedures I have followed in this study emphasize the narrative analysis of a set of interviews. In this section I will present the manner in which the interviews were analyzed by myself working individually and in conjunction with an interpretive group. This reporting of the methods used for the analysis of the first interview question are themselves presented in a narrative account. The present discussion of text analysis shows how the specific analytic procedures were progressively modified to disclose, as fully and as accurately as possible, the cohesion and diversity of psychotherapists' discussions of their experiences of managed care. Since other researchers in this tradition have thoroughly detailed the specific analytic procedures, it may be more useful to reflect on the process of adapting these procedures to a phenomenological "object" that is constituted through the interplay of the personal and social dimensions of experience.

The interviews were transcribed in a verbatim form taking out any information that could potentially identify an individual participant. For example, the names cities and the names of their patients employers, insurance companies or managed care companies were omitted. One of the verbatim transcripts is included in Appendix C. I presented two full transcripts from the first three completed interviews to the interpretive group for review of the interviewing process. During these presentations preliminary group analyses of significant statements and themes derived from the protocols were done. Significant statements are those parts of the transcript which communicate a distinctive meaning about an experience whereas themes gather these significant statements into a coherent structural dimension of the life-world (Barrell, 1987; Dapkus, 1983).

After nine of the interviews were transcribed, I followed procedures which drew on this form of analysis of significant statements to determine themes for each of those nine interviews. This resulted in a long list of "themes" that gathered together a common meaning for groups of significant statements. The thematic analysis was done examining common patterns among all of the interviews. Working alone, at that point, the analysis of themes looked like all trees and no forest.

This long list of themes and segments of the transcripts were then presented to the interpretive group. This led to a discussion which seemed to re-configure the themes into a set of four themes and a phenomenological structure for relating them to each other. A subsequent discussion with two senior researchers from the interpretive group also helped provide

appropriate names for the themes.

The following experiential themes emerged: *autonomy*, *change in self*, *change in therapeutic relationship*, and *ethical/moral stance*. The naming of themes and a subsequent re-analysis of transcripts in relation to the phenomenological structure was done as a result of further decisions on my part and is my responsibility. The re-analysis of the transcripts led to the identification of distinct topic shifts within the dialogue (Mishler, 1984; 1986). These topic shifts were identified in terms of specific transactions between the participant and managed care reviewers or patients, including filling out review forms and setting fees. The topics also were identified by coherent spans of text that addressed a focal concern. Topics of this sort included, for example, general comments about managed care or professional organizations, discussion of the operations of a specific managed care company, and discussions of specific clinical cases.

Seidner's (1987) and Hawthorne's (1988) methods of narrative reduction were adapted to the task of identifying the focal topics of concern (situations/transactions). This meant that, for some of the interviews the temporal organization of the dialogue was re-configured. Parts of the transcripts that were not contiguous were re-arranged so that a continuous and coherent situation/transaction was identified. This process can be traced by examining and comparing the summaries of the situation/transactions for the paradigmatic case (Appendix B) with the verbatim transcript (Appendix C).

Once experiential themes, phenomenological structure, and

situations /transactions were in place, I re-analyzed each transcript. This re-analysis yielded a list of situations/transactions for each participant. Each situation/transaction was summarized in a narrative form and was composed of significant statements. Each situation/transaction was then analyzed to determine which themes and configurations of themes were present. The following chapter has been structured so that this process can be carefully traced. A description of general experiential themes and thus phenomenological structure is presented first. A single interview is then analyzed in detail showing how the experiential themes and structure articulate each situation/transaction. Finally, configurations of themes for each participant's situations/transactions are presented in narrative descriptions and in summary tables. Hopefully, this set of analytic tools will allow the relevant life-world for each psychotherapist to be described comprehensively.

CHAPTER III

RESULTS

This chapter is organized into three major sections. In the first section, a general thematic analysis for all participants is presented. This is followed by a presentation of the phenomenological structure that configures this thematic analysis and provides the context for describing the ways in which psychodynamic psychotherapists in private practice experience the impact of managed care. This structure is meant to represent the dynamic interactions of four experiential themes: *autonomy; change in the therapeutic relationship; change in the self*; and *ethical / moral stance*. These themes articulate the meaningful structure of focal situations and events (most typically transactions involving therapists, patients and managed care reviewers) together with the background context of lived experience pertaining to the impact of managed care on these therapists. Verbatim excerpts from the interviews are presented for each of the four themes. This phenomenological structure is also meant to describes the therapist's lifeworld in which the interplay of individual dispositions and social positions is articulated. This way of approaching the present set of descriptions cannot be understood apart from its functioning in particular descriptions of specific experiences and actions in particular social contexts.

In the second section of Chapter III, the analysis of a single participant's interview is presented as a paradigm case. This case is presented to exemplify the present method of analysis. All interviews were divided into a series of situations/transactions: that is, a coherent span of the dialogue gathered together by a common set of interpersonal interactions or more general concerns about a focal dimension of the lifeworld. The interview selected as paradigmatic was partitioned into nine situations/transactions and a detailed application of the phenomenological structure is presented for each of these situation/transactions. The process of dividing the interview into situations and transactions is presented in Appendix B; the full transcript is presented in Appendix C. Each situation/transaction is summarized in a third-person descriptive narrative form and each descriptions concludes with a geometric figure attempting to place some significant statements within the phenomenological structure. Representing the situations/transactions with these figures is important because it demonstrates the way in which various themes form a dynamic configuration. This manner of presenting results also reveals that many of the statements made by the participants are best understood as a blending of themes. The second section concludes with a representation of the thematic configurations for all situation/transactions in the paradigmatic case.

The third section of Chapter III presents a summary of experiential themes pertaining to descriptions of situations/transactions for all ten participants. The results of this thematic analysis are presented in table form for each participant. A brief narrative summary of each participant's entire interview is first presented and then followed by a description of the

thematic analysis which introduces the summary of all situations/ transactions for that participant.

Each section builds upon the other. Although the themes are presented separately in section one, the thrust of any phenomenological analysis is that the themes form a unity, and a statement or set of statements from an individual participant's interview can only be understood as a blended relationship of one or more themes. This is the reason why I have emphasized a detailed presentation of the paradigmatic case following the more general discussion of experiential themes.

Experiential Themes

An existential-phenomenological analysis distinguishes a set of themes that describe the particular object of study through an articulation of the lived meaning(s) of the phenomena. A pattern of themes usually emerges, and this pattern is then presented in the form of a geometric figure to emphasize the interrelationship of experiential themes. The emphasis on the interrelationship of themes is even more pronounced in present results. The themes themselves are only relatively distinct from one another and each theme gathers together a range of meanings. There are four themes: *autonomy; change in the therapeutic relationship; change in the self*; and *ethical/moral stance*. Each of these themes will be discused in turn. In this study, verbatim excerpts that have been chosen to exemplify a theme are usually several sentences long. These excerpts were chosen because they focus on the theme under consideration, although most excerpts concern more than one theme.

Description of Themes

Theme 1: Autonomy

This theme concerns the point of impact -- that is, the manner in which managed care introduces an actual or potential change in the therapeutic relationship, the therapist's practical working conditions or in the therapists' feelings, attitudes, judgements and/or actions. The theme of autonomy gathers together specific ways participants experienced third or fourth-parties and their attempts to influence the therapist-patient relationship. For example, the participant selected for the paradigm case directly stated that s/he felt managed care made personal working conditions feel less autonomous. Some therapists described managed care as a "silent partner" looking over one's shoulder, and some identified specific reviewer actions that affected the course of treatment or reimbursements for specific patients. Some participants also referred more indirectly to concerns about autonomy in the context of their ability or inability to join closed panel preferred provider organizations (PPOs) and the economic impact this had for them. Although the term *autonomy* was selected to name this theme, the theme refers to the broad range of impact that managed care can have. Some therapists experienced managed care as creating a change in their context of practice but described these changes in more benign terms.

The following excerpt presents a direct statement about autonomy:

> Participant #7 -- "When I begin to realize that what I have conducted completely autonomously up to now, or quite autonomously, is not as autonomous as it used to be. And I don't feel generous toward it and my initial reaction I feel resentful and then what I try to move toward is a more balanced view of

it, when I stop and think about it I am aware that the money that is available for clinical work or long term dynamic psychotherapy is limited and that there has to be some means for distributing the money that is available based on clinical criteria."

Another participant described managed care as "background noise" that emerges only when a review process is underway:

> Participant #6 -- ..."at those periods of time when I have to do the reviews, those things came up and in fact, it has not at this point been a problem. Meaning that they have not disagreed, I suspect I'm coming up on a point when that will happen, but it is a struggle to reconcile, to say things in such a way that you say them accurately, and be mindful of the audience which is reading them. Which is usually not a dynamically trained [mental health professional], but you know, sort of a clerical type, maybe with some sort of a professional degree but certainly not a person who is in a room with a patient and in anyway can know the way the therapist would know."

The following excerpt describes how a managed care reviewer directly intervened with a patient's family prior to contacting the therapist, which raised the issue of autonomy:

> Participant #4 -- "Managed care comes along. This is also in the context of a kid who had been raised the first few years by an aunt and then returned to her mother so there is major abandonment issues. Then managed care comes along and without contacting me the case manager writes the mother, says that in his experience it has been fruitful to talk to families about treatment and he wants to arrange an appointment to talk with her about the care of this child. The man had not talked to me yet."

The following excerpt describes how the presence of managed care affects a therapist's sense of autonomy right from the start of treatment:

> Participant #9 -- "Even though I would say that if you look over the cases I have had in practice which has been almost 20 years I have been in private practice I am sure the modal case is probably eight or nine or ten sessions. So it happens that way anyway, but there is something different about it happening that way and my having to answer the kind of questions I do

> now for managed care outfits like "how long do you think this will take?" and trying to approach cases in their way, they are very much right in it with you. One particular managed care outfit I belong to [name of company omitted], you have to call them after the first session and it is really like having another clinician looking over your shoulder..."

Theme 2: Change in therapeutic relationship

This theme refers to those features of experience that involve a specific alteration in the working conditions of fee-for-service private practice or that involve a description of alterations in the therapeutic relationship between therapist and client. Some participants described how specific issues concerning confidentiality, reimbursement benefits and policies, release of information forms entered into the treatment process as a consequence of managed care reviews. This theme also refers to the impact that managed care may have on limiting the length of treatment or on the specific techniques that a therapist might use in treating a particular patient.

The following excerpt describes how a specific managed care company that operates on a strict ten session model affected a specific patient:

> Participant #9 -- "I let him [the patient] in from the beginning that there was someone looking over our shoulder and when I told him which was like after five sessions that we only had five more sessions you could watch his face fall. So this is having a very heavy impact on this case because he will get five more sessions. He will have gotten something out of it, but he could get more out of more treatment...If I could say he was suicidal I could get more sessions for him, and they are quite clear about that at [managed care company name omitted] that they will let me see someone twice a week or three times a week to keep them out of the hospital."

The participant's description in the following excerpt indicates how therapeutic techniques may be influenced by the limited number of sessions that a managed care company will reimburse:

> Participant #1 -- "If I did not feel constrained to get a hook into her I would be much more willing to focus more on her feelings and what her experience is like rather than on the much more practical aspects of the day to day functions which I feel are directly related to her feelings of affective experience. I just have a sense of urgency of what can happen in so many visits because I know she will probably go to the 20 visits, I think we are probably at eight or ten....I think that I would be much more self psychologically or psychodynamically oriented around having a empathic response to this women's experience in the world. If I felt that she was going to be able to continue over time and if she were not going to say "what visit am I at now?" It is a trade off I guess. I am not an ideologue, so I can make the shift I think to more short term, pragmatic focus, but I think in this particular women's case it would be nice to be more empathic with her."

The following excerpt describes how time limits may be experienced as positive:

> Participant #3 -- But with the managed care I really try to at least come up with a preliminary take within the first couple of sessions and then what I do with the patient is I nudge them. There is no way that we can know each other very well at this point, and here is the initial take on a direction we could go that would be useful for you instead of goals in therapy that are doable for you. Keeping in mind that we can change where we are or what level or depth we want to work later on. This seems like a reasonable starting point. I do that very soon, so that is one way they help you when they are calling up and reviewing you.

Managed care reviews also raise issues of release of information and confidentiality. The following excerpt describes how one participant experienced this as having a beneficial effect on the treatment relationship:

> Participant #7 -- "I show them what I have written and they read it over and the times that has happened which has only been two or three times when we have had that detailed of a

conversation about it. Nobody has had any objection, even not very many questions about what I have written. It has worked out OK. Another reason that I find it beneficial to write these reviews is that it makes me more accountable to my patient about how I think about what they are doing in therapy, about what we are doing in therapy, because I write very carefully so as to be truthful but not so revealing of detailed information that it would be a betrayal of confidentiality and that seems useful to me. My sense has been that the patients have been, ah, I was going to say grateful but that's too strong a word, that they have a positive feeling about the fact that I have put that much thought into what we are doing together because aside from our day to day or session to session contact with one another they don't have evidence of that, so for them to see it in writing it tells them something about how much they are in my mind, that they matter to me, enough that I would take the time to do something like this. So in that sense there has been something of a positive result of these discussions."

In the most extreme cases, managed care may be experienced as having a damaging effect on both the therapeutic relationship and on the patient. This is forcefully presented in the following excerpt:

> Participant #4 -- "Shortly thereafter [after family was contacted by managed care company], and this is kid who had not really been interested in guys, she wasn't dating anyone, there was a lot of infatuation with this one fellow. Shortly thereafter she comes up pregnant. There had not been sexual acting out before this. The managed care people would not draw any kind of special inferences from that. Part of what got lived out there was she got so scared that, in some way that she was absolutely powerless to prevent, her involvement with me, there was no father here, was going to get snatched away. I was essentially the reliable empathic presence for this kid. She was envisioning that was about to be snatched away and she did exactly the thing that would send her mother into a tailspin and disrupt her work. It was really tragic because there had not been any kind of activity like that before that disruption."

Theme 3: Change in Self

This theme involves changes both in the participant's personal and professional life. Experiences with managed care frequently involve strong

feelings that may be directed toward managed care reviewers, patients, professional colleagues, or oneself. Directly experiencing managed care reviews, or even anticipating changing working conditions, may also lead to decisions about major personal life decisions, adjusting fees, and/or treating specific patients.

The following excerpt describes the sense of disruption and related feelings of rage experienced by Participant #4 that led to the choice of resigning from the Preferred Provider Organization (PPO):

> Participant #4 -- I resigned from the [PPO] because their presence was so disruptive to any kind of ongoing treatment and it was so disruptive, not only to the relationship, the issues that needed to be attended to because you never knew, you could never anticipate a course of treatment for somebody because there was always this sword of damocles, you never knew if five sessions down the line if the benefits were going to be terminated. The level of rage that I was that I was operating with given the constant bombardment, harassment, having to call every few sessions and go through a 15 minute to a half hour discussion at that point probably on 24 patients...Every time, you go through this and you go through this same long descriptive process with every one of them having to justify treatment. The behavioral descriptions, the level of rage that came out of that kind of intrusion, I realized I wasn't going to be of any use to people, certainly given how disrupted I was feeling in the face of this.

The following excerpt explores some of the personal reactions a participant had to the review process of difficult-to-treat patients:

> Participant #10 -- "...I feel a kind of silent rebuke that is largely my own projection I am sure as I talk with these reviewers or fill out the forms I feel rebukes along the lines so why do they still need help after all this time. I know the truth of the matter but I also feel a sense that one should be able to do something for somebody quicker than he actually can. So I believe that one of the things that makes me exasperated with difficult cases that also have forms to fill out and phone calls to make, one of the things that exasperates me is my own sense of guilt over not being powerful or grand enough as a therapist to effect a

miraculous transformation and the unspoken rebuke which is certainly my projection whether it is there or not. The unspoken rebuke: so why don't you help this person."

The next excerpt describes that the impact of managed care on the self involves concerns about making a livelihood:

> Participant #1 -- "Alright, the major impact that it [managed care] has had has been on my ability to, or my inability to become a provider. Certainly major ones, exclude because I am recently licensed, and they have their quota of providers and are not interested in seriously considering new providers....And this obviously impacts on my ability to make a living."

The experience of change in the self may also blend concerns about economic well-being, interpersonal relationships and the control over her/his own professional work arrangements:

> Participant #8 -- "Well I belong to a group and we are debating whether or not to become providers for a certain managed care company and we are well aware that there will be compromises in our fees and one of the considerations is managed care in general seeks to avoid hospitalization....So that if a patient presents at an emergency room say at midnight and the clinicians promises to arrive at 5:00 am that is a way for the emergency room and the managed care company to satisfy their issues of responsibility that the patient will receive services in the near future and so that is a consideration. I'm not thrilled with the idea of bounding out of bed at anytime because someone is willing to pay for that service. But there are other people in the group who feel differently. I also am the one I should add who lives furthest away from where all this activity would take place."

Theme 4: Ethical / moral stance

This theme gathers together explicit or implicit beliefs and concerns about fairness, justice, and particular moral values. Concerns about fairness and procedural justice were raised in the discussion of the impact of managed care on specific patients. Fairness also was discussed at a societal level, and

several participants raised concerns about the proper allocation of scarce resources for long-term psychotherapy. Some participants also identified particular values about the types of patients who deserve reimbursement for long-term psychotherapy and their own present values relating to the quality of care. They discussed value judgements relating to arranging reduced fees or to providing free care to clients. Basic value conflicts with managed care were also frequently discussed.

The following excerpt identifies features of an ethical dilemma about providing free care to patients whose third-party reimbursement was exhausted.

> Participant #8 -- "...it is a dilemma because you only have so many hours to work and basically you have to learn a living at it. But I think there were ethical issues involved here as well and these were people who I just thought might not get care otherwise. Certainly these were people who despite having very severe disorders had formed good relationships and working relationships with me and I just was not willing to give that up. Both of them drive a considerable distance to see me, one drives an hour and one drives and hour and forty five minutes each way to get to my office. My feeling is that if they are willing to that I guess I can donate those two hours a week of my time."

An excerpt from the participant selected for the paradigmatic case shows the depth of commitment to the value of practicing long-term psychodynamic psychotherapy based on a variety of personal and professional experiences:

> Participant #7 -- "I see long term therapy as a way to get to the roots of things and help people make truly profound changes. That is something I value very much. I find it deeply gratifying and part of the reason that it is so deeply gratifying to me and that I believe in, I truly believe in it, is that it has worked for me. I am a long term patient in therapy and it has transformed my life and I know it works. Certainly that is a part of what underlies the fact that I value it so much. I see it working in my

life and I see in working in the lifes of people I know and love also, peers, friends.. So that is a part of it, a personal experience with it and so I orient my life in that way toward a dedication to long term change that is at a very profound level and I have to say I do value that I feel more personally invested in it and I believe it is the way the most true change can happen."

The following excerpt explicitly states a conflict in basic values between the participant's sense of doing psychotherapy and his/her experience of the values of managed care:

> Participant #6 -- I think more important to me the reality of helping human beings is that it takes time. And real helping, I am not talking just about sort of behavior modification behavior change where you just want to limit some manifest bothersome habit and so you construct some sort of regimen to do that over x number of weeks, but I am talking about more sort of changes in the soul, if you will, take time and this managed care industry proceeds from a real medical model, real mechanistic view, the parameters are based upon a different epistemology.

Some ethical and moral concerns were presented in a more implicit way. The following excerpt expresses values about types of classification procedures for analyzing such data and the significance such analysis has for the operation of managed care:

> Participant #4 -- "And the reviewers were not operating in good faith, number one. Meaning it wasn't like I had sense of people who really trying to understand what a case was like, really trying to understand the human being. They were operating from some list of DSM-III based criteria, ostensibly, and they were operating on a statistical model that they were deriving from their own data. So you have this kind of circular process whereby which they won't allow sessions after a certain length of time. So then they can say, people with this diagnosis never have sessions longer than..., if they cut people off at ten sessions then they can start saying statistically people with this diagnosis never had more than 10 sessions. That kind of hypocrisy was just infuriating, absolutely infuriating."

Phenomenological Structure of Experiential Themes

It is most accurate and effective to view the four themes as forming a single configuration or structure in experience. This structure is presented in Figure 2. As is apparent from some of the verbatim excerpts above, many statements and larger spans of text that have been marked off as communicating a distinctive meaning about a situation/transaction are actually best characterized as a blend of themes. For this reason, the thematic description of a situation/transaction is best represented in the form of a geometric figure with significant statements placed in the space between themes that are located at the four corners of the diamond. The application of this structure will be demonstrated in the following case study.

Paradigmatic Case Analysis

The interview chosen as paradigmatic was selected because it exemplifies a self-reflective style and provides a richly textured description of experience. This interview also was chosen because it provides a clear sequential division of descriptions of situations and general comments. To put this in another way, this participant seems naturally to organize the dialogue into clearly bounded topic shifts that are easily recast into a series of phenomenological structures.

In addition, this interview can be characterized as paradigmatic in several important respects. Most of the descriptions or comments display an interconnection of experiential themes. The ethical/moral dimension is most thoroughly developed and integrated with other themes in this interview.

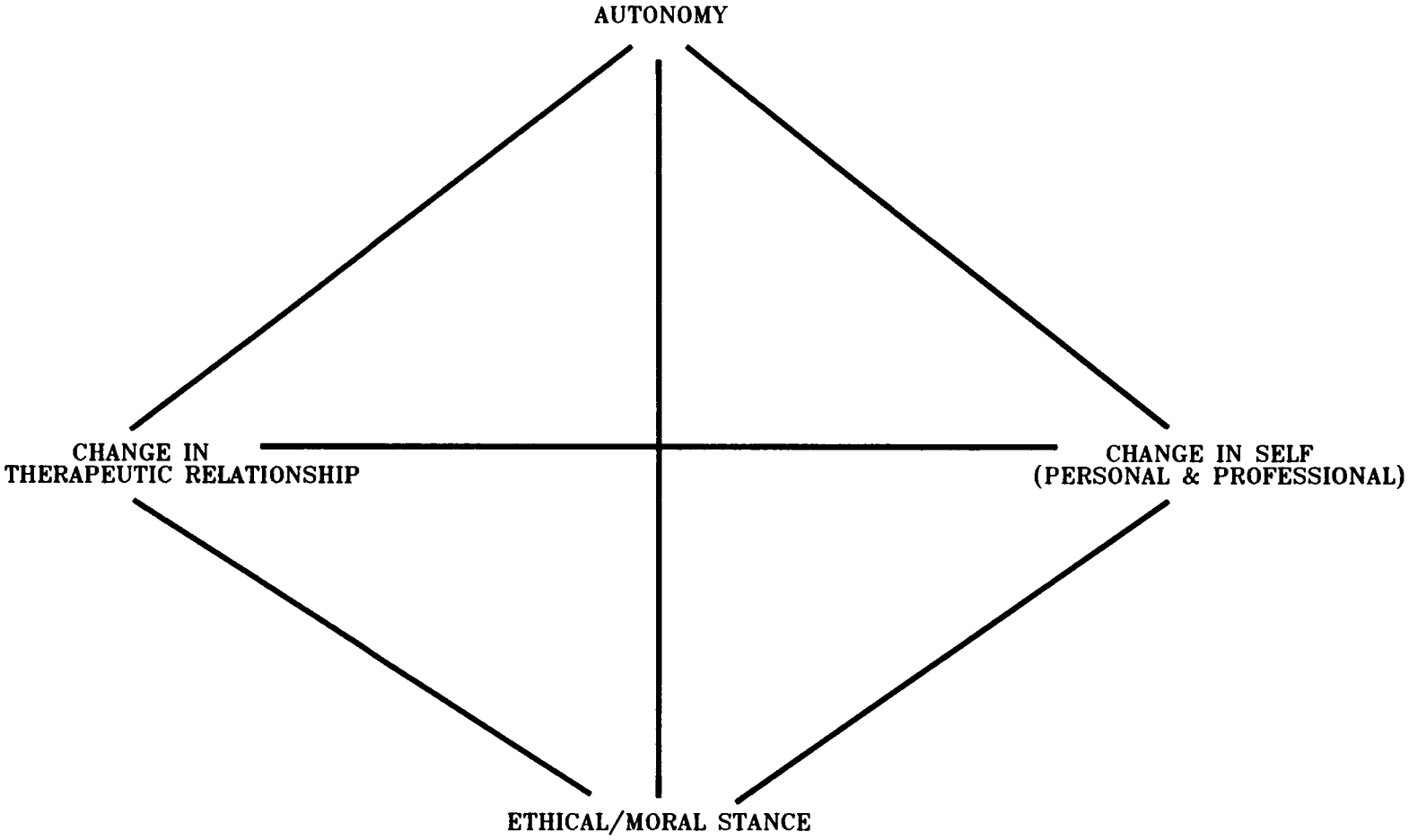


Figure 2. Phenomenological structure for psychodynamic psychotherapists experience of managed care

This interview is also paradigmatic because it presents a greater articulation of ethical perspective-taking compared to other interviews. During the course of this process of perspective-taking there is an acknowledgement of the positive and negative features of managed care and this interview presents a fairly balanced perspective on the positive and negative features of managed care in comparison to most other interviews. This interview also presents the most clear cut discussion of the range of issues and choices therapists must grapple with if they aim at preserving the greatest degree of clinical autonomy from managed care.

Just prior to the start of the interview the participant told me that issues relating to managed care were quite important and that they had been given considerable thought. In fact, the participant had made some notes about experiences with managed care based on the interview questions and format of the interview as described in the informed consent form. During the interview, however, this participant spoke spontaneously without the use of notes. After the data analysis was completed it was shown to the participant for comment and review. This participant felt that the form and content of the analysis were accurate and comprehensive. This participant also requested that gender markers not be used to ensure a maximum protection of privacy. Although these conventions are awkward they will be used in presenting results for all participants in order to ensure their privacy.

Thematic Analysis of Situations/Transactions

This participant's interview divided into 9 situation/transactions. A

situation/transaction is a span of text that coherently organizes a common set of interpersonal interactions or more general concerns. Significant statements will be placed within the phenomenological structure to depict the interrelated meanings in each description. A narrative summary in the third-person voice is presented for each of the situation/transactions.

Situation / transaction #1 - Responding To Communications From Managed Care Reviewers

When this participant has written communications with managed care reviewers, s/he felt intruded upon and realized that private practice work is not as autonomous as it used to be. This potential threat to autonomy brings on feelings of anger and rage. S/he experiences her/himself as being emotionally reactive to these communications from managed care and makes an effort to modulate such feelings. When s/he modulates these feelings s/he becomes more productive in her/his response to managed care reviews. The managed care reviews also elicit feelings of resentment that are related to a moral reflection on the motives of the managed care companies, whom s/he views as being motivated solely by financial considerations. S/he is able to move away from feelings of resentment by reflecting on a need to balance the requirements of various parties. S/he realizes that there are only limited financial resources available to pay for psychotherapy and fair criteria are needed to distribute such resources. This thematic analysis of situation/transaction #1 is represented in Figure 3.

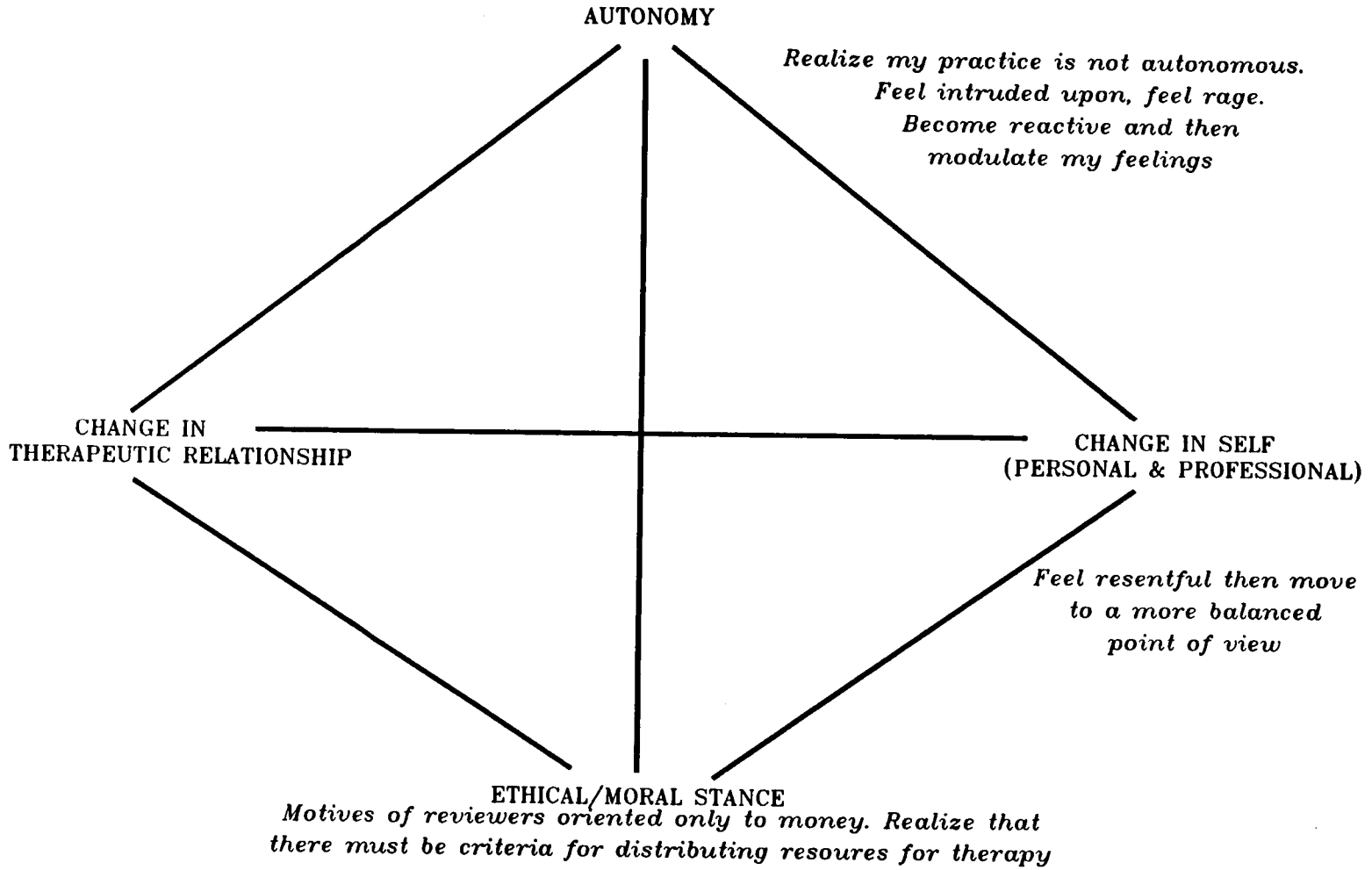


Figure 3. PARADIGM CASE (Participant #7) Situation/transaction #1: Responding to communications from managed care reviewers

Situation / transaction #2 - Completing Managed Care Review Forms

This participant makes a special effort to modulate feelings of anger and resentment when working on managed care review forms. A special effort is needed to modify such experiences at these times and this effort helps her/him to see some benefits in completing the review forms. S/he modulates feelings in order to be an effective advocate for patients. Acting as an advocate in the context of managed care reviews appears to be a value orientation. Although these forms do not promote expression of her/his own form of clinical understanding, the process of completing such forms helps this participant to organize clinical thinking. This participant chooses to discuss the processing of review forms with patients and s/he shows them what s/he has written. This therapist felt that this has led to positive changes relationships with patients. S/he felt that these forms provide patients with written evidence of thoughtfulness and concern for them in ways not evident in encounters in the psychotherapy sessions. This participant also identified values of being truthful when completing the forms and of maintaining patient confidentiality. This thematic analysis of situation/transaction #2 is represented in Figure 4.

Situation / transaction #3 - Processing Release Of Information Forms With Patients

This participant experiences a heightened awareness of the presence of third and fourth-party reviewers when s/he is discussing release of information forms with patients. When a managed care review is part of a patient's third-party reimbursement this participant chooses to discuss the

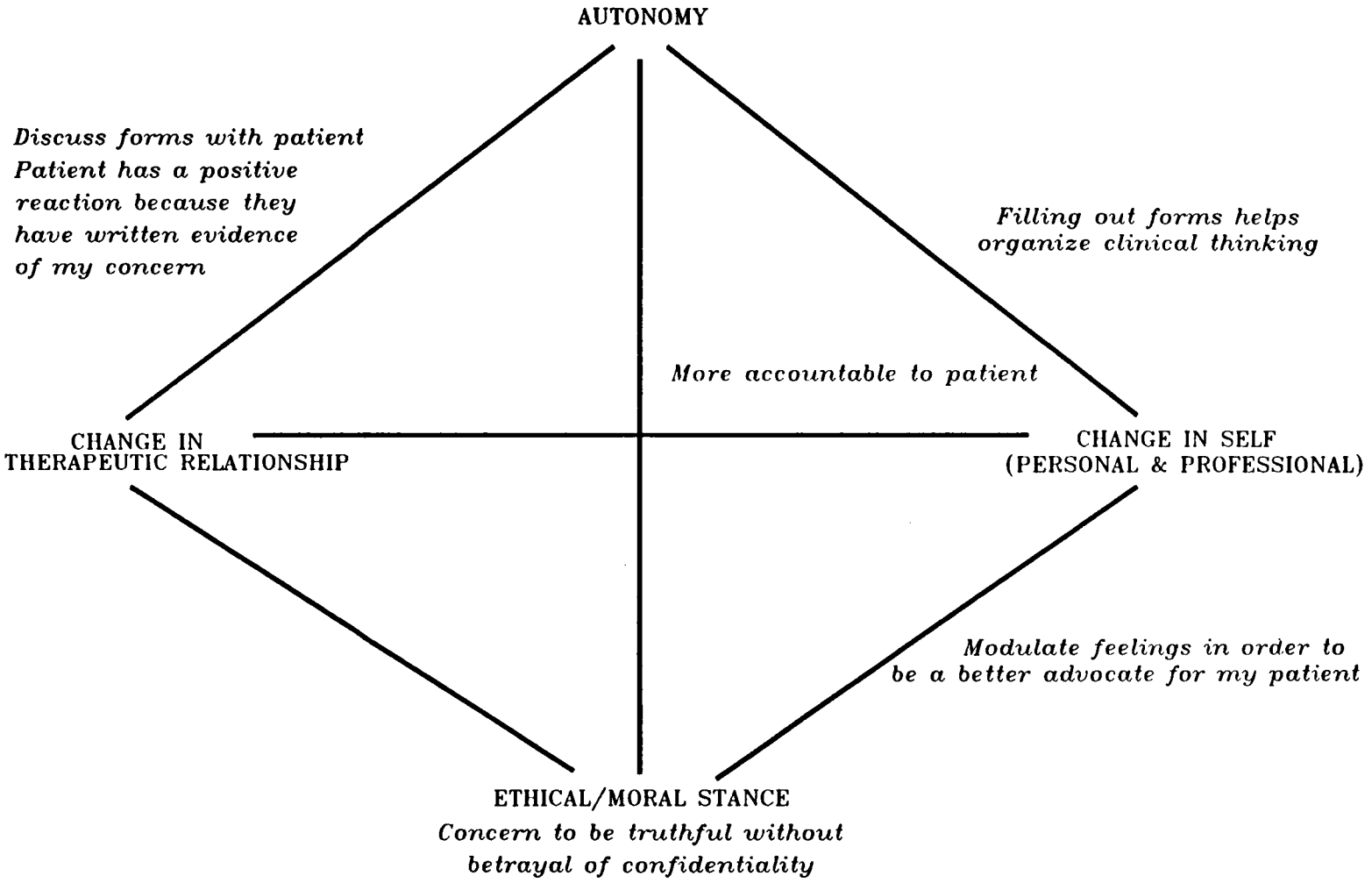


Figure 4. PARADIGM CASE (Participant #7) Situation/transaction #2: Completing managed care review forms

implications of the release of information with patients. The fact that release of information forms are needed in this context leads this participant to feel resentful. S/he makes a special effort to modulate these feelings before discussing these issues with patients. Reflecting on the broader need to determine a fair distribution of resources (insurance money) appears to help modulate her/his feelings of anger and resentment toward managed care. Reflecting on ethical concerns appears to help this participant to discuss the release of information forms in a more therapeutically productive manner. This thematic analysis is represented in Figure 5.

Situation / transaction #4 - Responding To The Impact Of Managed Care On Professional Peers

This participant has been most acutely aware of the impact of managed care when talking with professional peers. S/he has felt that peers experience these reviews as conducted in an arbitrary manner. This state of affairs aroused feelings of anger and resentment in her/himself. This participant has also felt fortunate that s/he had time to plan ahead before feeling the direct impact of managed care on her/his own private practice. This participant experienced the discussions with professional peers as facilitating personal planning and decision-making. This thematic analysis of situation/transaction #4 is represented in Figure 6.

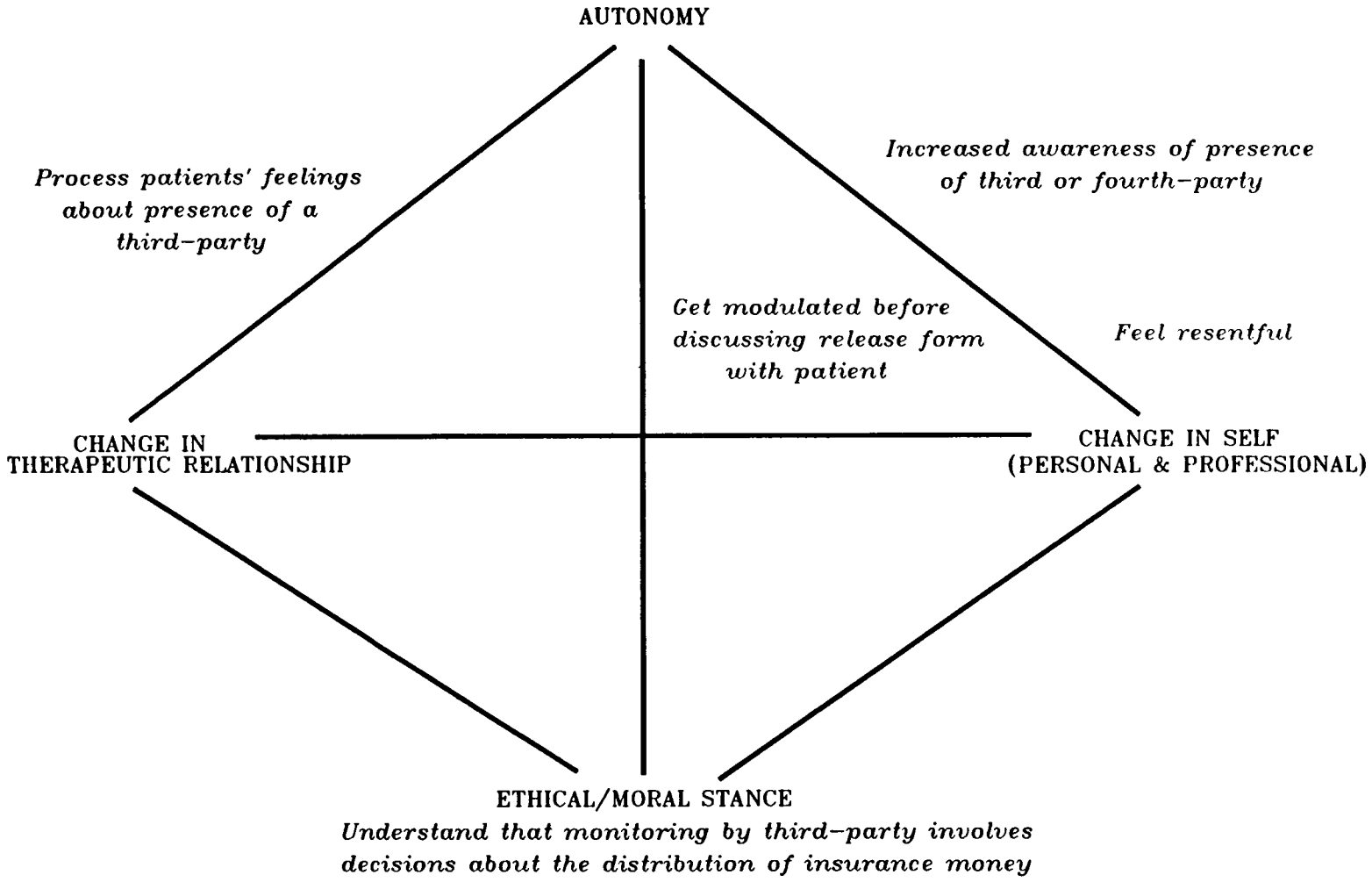


Figure 5. PARADIGM CASE (Participant #7) Situation/transaction #3: Processing release of information forms with patients

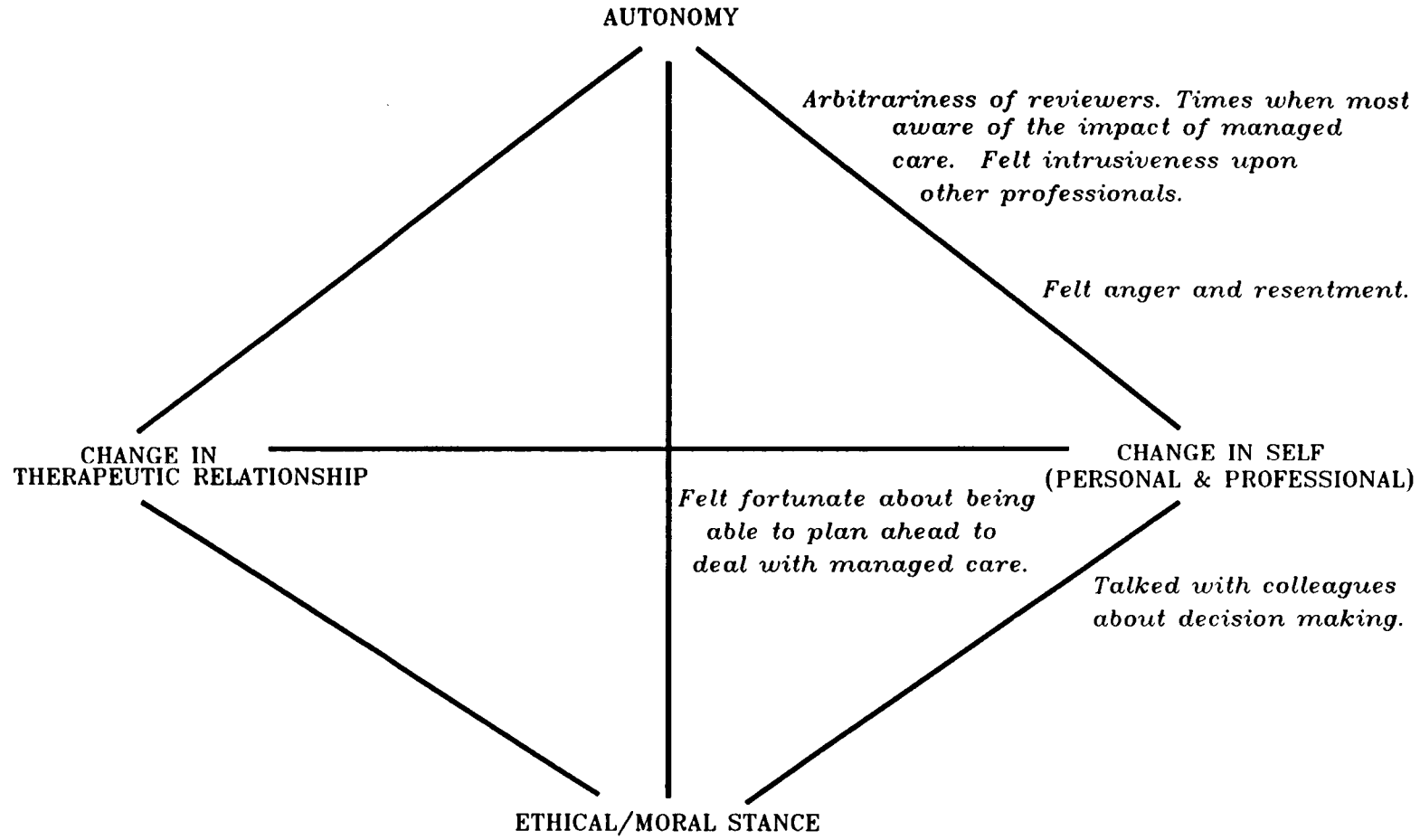


Figure 6. PARADIGM CASE (Participant #7) Situation/transaction #4: Responding to managed care's impact on professional peers

Situation / transaction #5 - Personal Responsibility And The Responsibility Of Professionals

This participant expressed general concerns about taking personal responsibility in private practice. The concerns about responsibility also run through their discussion of other more specific situations and transactions. This participant's discussions of responsibility are clearly related to a sense that managed care is an intrusion on a domain once experienced as more autonomous. This participant described a process whereby s/he is able to move past a sense of rage about the intrusiveness of managed care and a sense of superiority over the reviewers by an effort of reflection and modulation of feelings. At that point, a sense of personal responsibility emerges. S/he also feels better when modulating feelings. This change in her/his sense of self is interwoven with an ethical recognition of the need to find a way to distribute the money available for psychotherapy.

This participant believes that managed care challenges therapists and patients with personal responsibility. This reflection leads to a consideration of the contradiction of accepting reimbursement based on a medical model while rejecting a medical model for psychotherapy. This set of reflections clearly involves ethical and moral considerations. S/he believes that if professionals continue to accept third-party reimbursement they must also accept the scrutiny of managed care. In that case, therapists should work conscientiously to justify the need for long-term psychotherapy to get the maximum number of sessions for their patients. Professionals are responsible for deciding to remain involved with third-party payers. This

thematic analysis of situation/transaction #5 is represented in Figure 7.

Situation / transaction #6 - Integrating Monetary Issues In The Therapeutic Process

This participant believes that the context of third-party reimbursement and managed care allows therapists to avoid certain responsibilities and decisions. S/he has had some patients make direct payments to her and then reimbursed them when insurance payments arrived. S/he feels this is a better arrangement and does not feel despair over the potential impact of managed care. This participant's sense is that more directly integrating monetary issues into the therapeutic relationship is helpful. Following through on this judgment and completing disengaging from third-party reimbursement would involve significant changes in this participant's private practice work. S/he feels that such a decision would involve an increased personal responsibility and more time devoted to the management of financial issues. If s/he refused third-party reimbursement, s/he would then be faced with decisions about adjusting patient fees on an individual basis. This participant expressed concerns that this might change the nature of her/his caseload. This raises the question of whether s/he wants to serve only those patients who can pay for treatment without third-party reimbursement. The thematic analysis of situation/transaction #6 is represented in Figure 8.

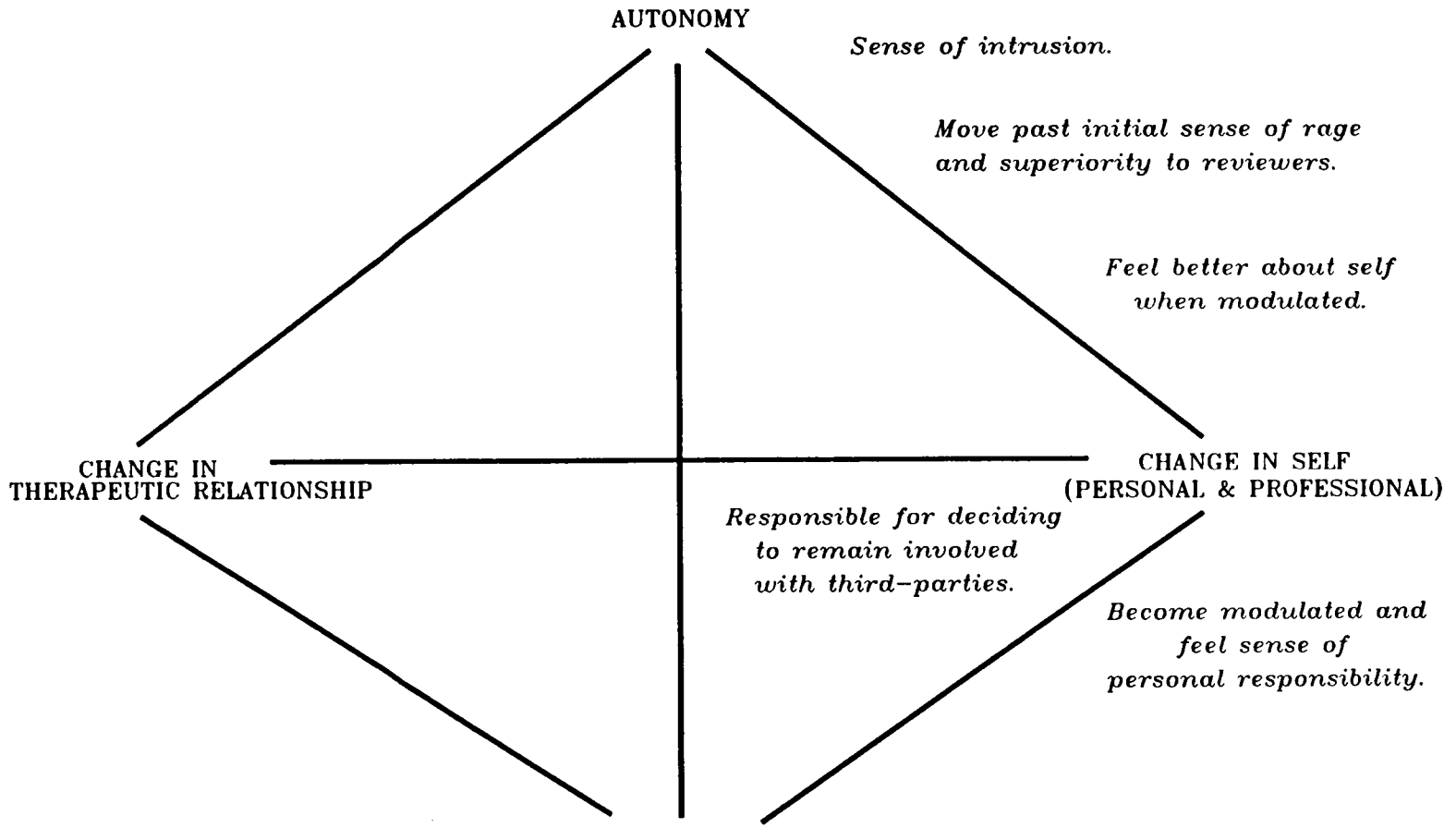


Figure 7. PARADIGM CASE (Participant #7) Situation/transaction #5: Personal responsibility and the responsibility of professionals

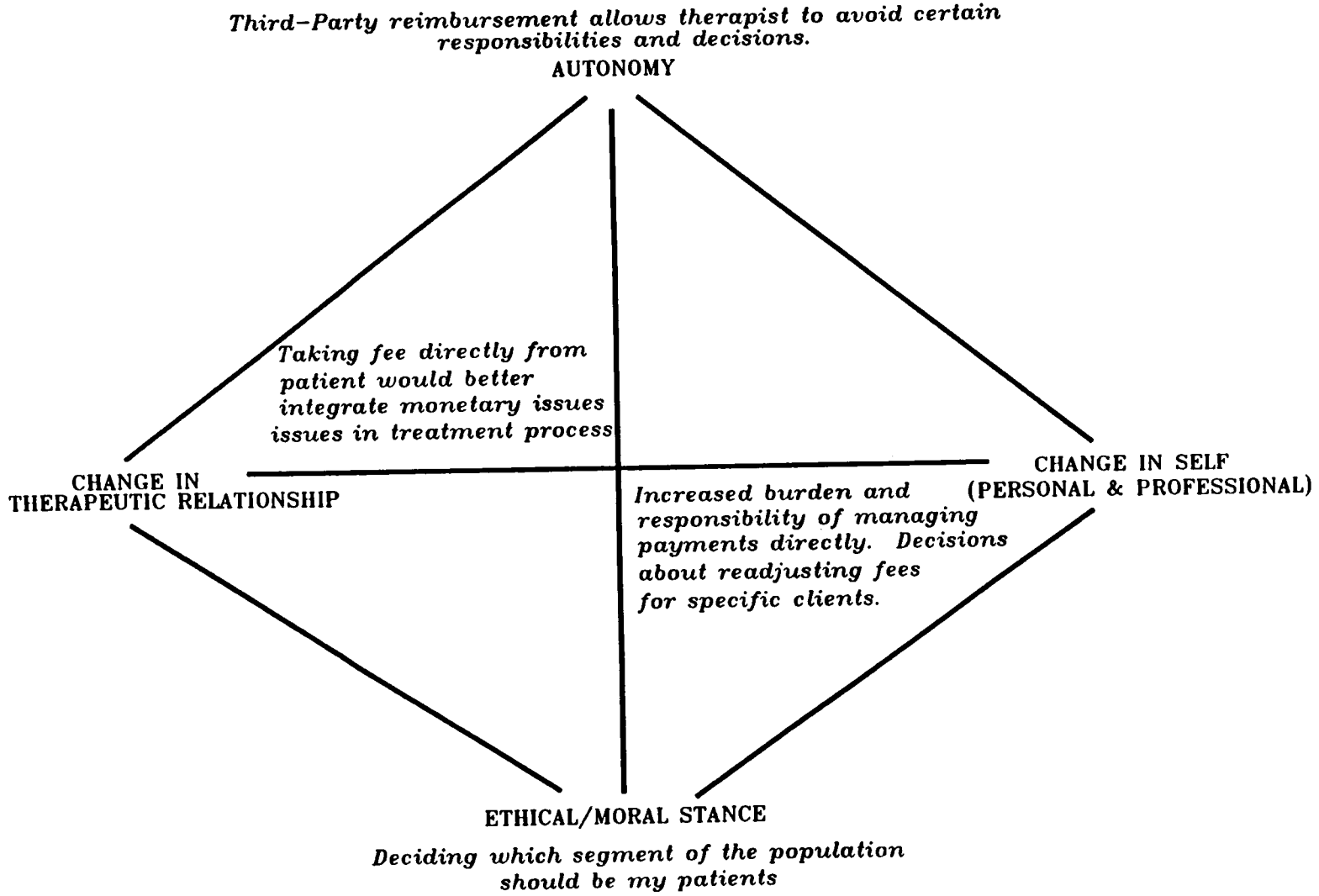


Figure 8. PARADIGM CASE (Participant #7) Situation/transaction #6: Integrated monetary issues in the therapeutic process

Situation / transaction #7 - Anticipating Lower Fees And Income

This participant expects that not accepting third-party reimbursement will mean a reduction in income. In any case, the impact of managed care will probably lead to a lower average fee. The choices of how to respond to manage care involve major life decisions such as where to live. (The specific details of this decision making were omitted for the sake of privacy.) The thematic analysis of situation/transaction #7 is represented in Figure 9.

Situation / transaction #8 - Responsibility To Educate Third Party Reimbursers

This participant described managed care reviews as intrusively and arbitrarily provoking confrontation with personal responsibility. The particpant's feelings of rage occur in the context of being confronted with aspersions about personal responsibility. S/he conscientiously completes managed care reviews because s/he feels responsible to specific patients and to increase resources available for long-term psychotherapy. This participant also feels a need to balance patient needs and her/his own needs in completing the managed care reviews conscientiously. S/he believes that these efforts may educate third-parties over time about the value of long-term psychotherapy but is not optimistic. This participant also believes that the mental health professions should educate third-parties about the needs for and cost-effectiveness of long-term psychotherapy. This belief appears to be a basic value. The thematic analysis for situation/transaction #8 is represented in Figure 10.

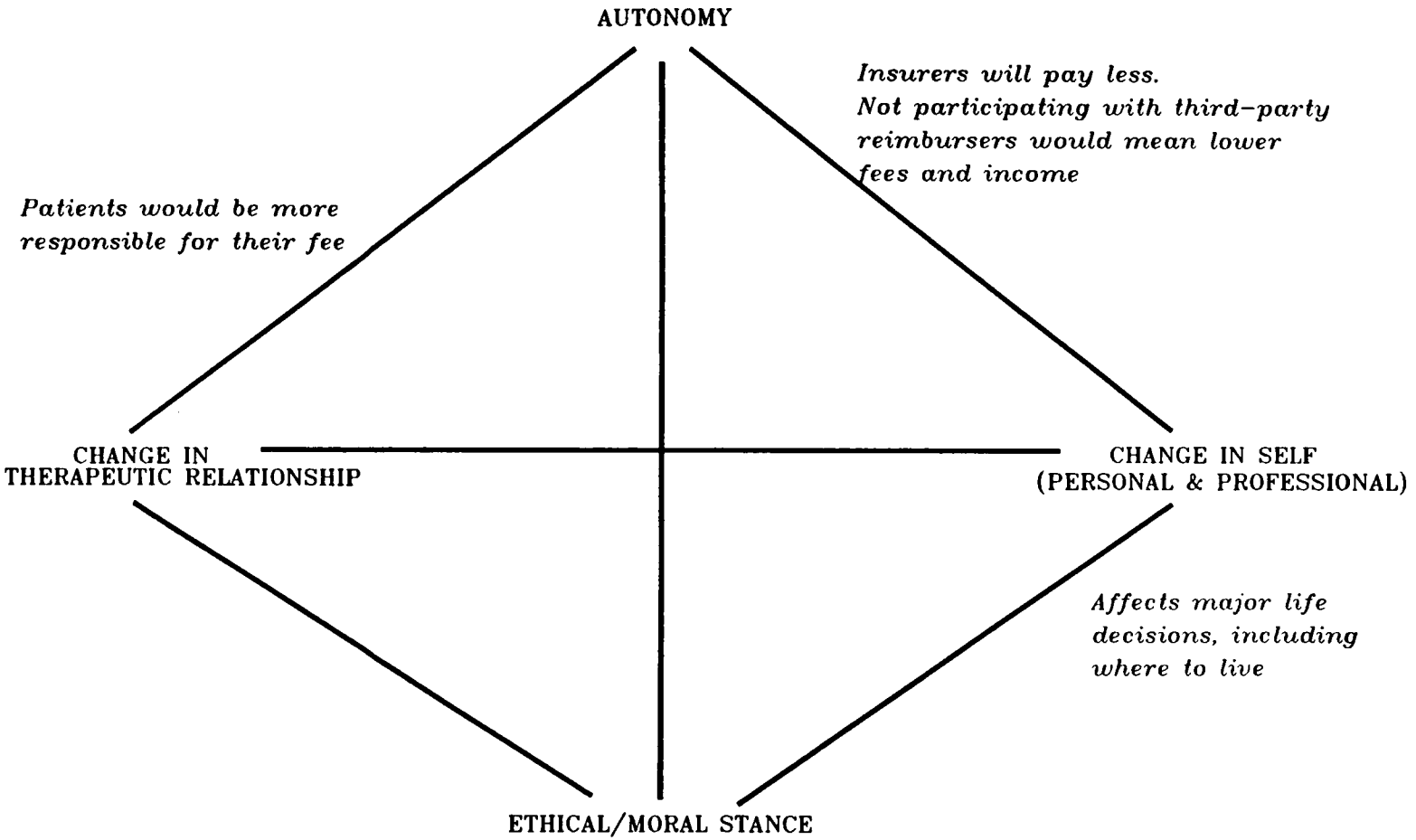


Figure 9. PARADIGM CASE (Participant #7): Situation/transaction #7: Anticipating lower fees and income

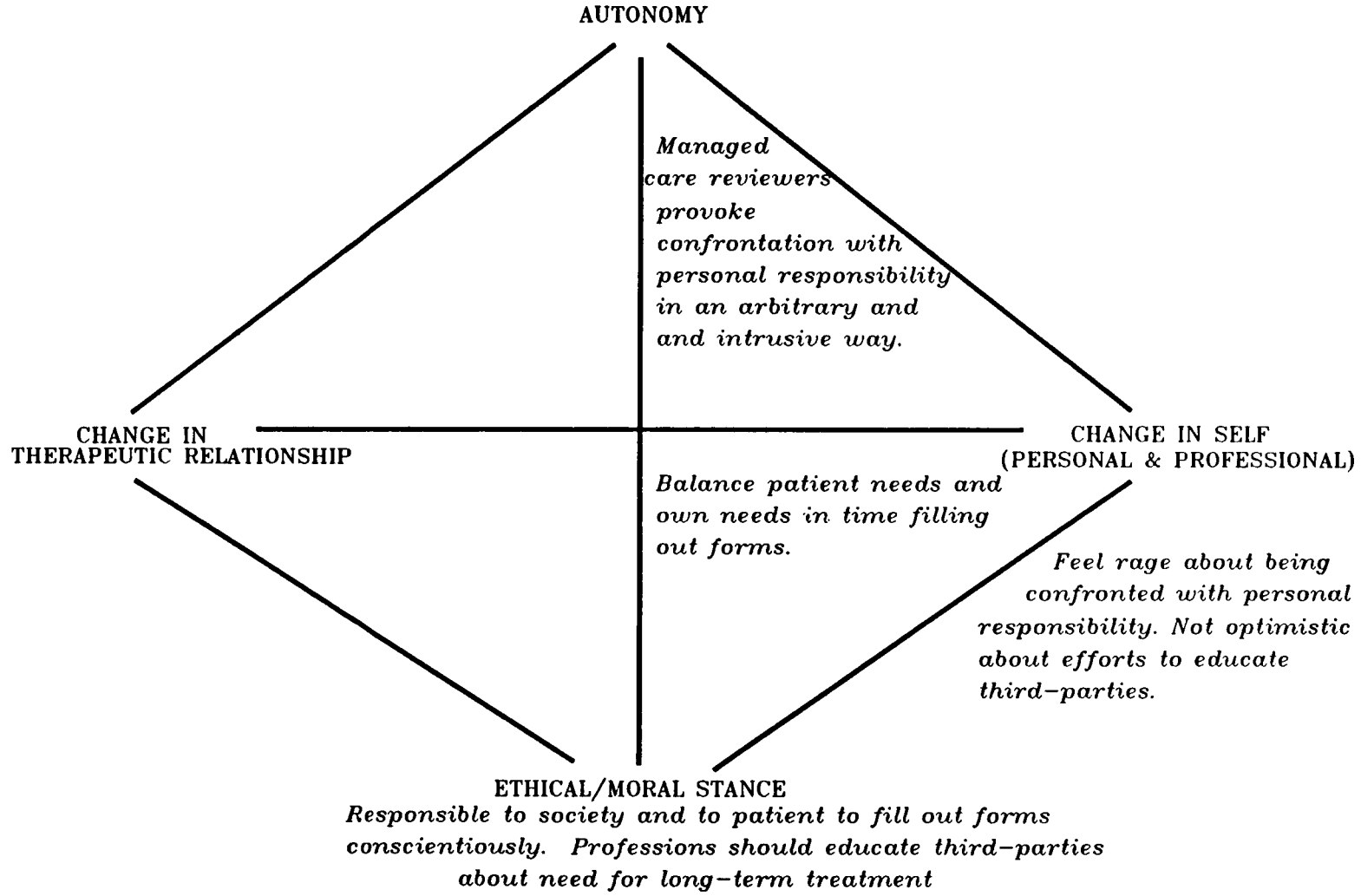


Figure 10. PARADIGM CASE (Participant #7): Situation/transaction #8: Responsibility to educate third-party reimbursers

Situation / transaction #9 - Doing Short And Long-term Psychotherapy And A Changing Professional Identity

This participant also considered remaining involved with managed care and felt that this would mean doing short-term therapy with a number of patients. This would lead to a change in caseload such that s/he would do both types of therapy and there would be a quicker turnover of cases. S/he also feels a need to learn more about the practice of short-term therapy. This participant felt that s/he is flexible and could seek primary professional gratification through a smaller number of long-term cases. This participant felt that being in personal long-term psychotherapy had been valuable and values long-term psychotherapy because it gets to the root of things and helps people make truly profound changes. S/he also understands that long-term psychotherapy is not good for everyone. This thematic analysis of situation/transaction #10 is represented in Figure 11.

Thematic Configurations for the Paradigmatic Case

Table 2 summarizes all of the situations/transactions that have been discussed in detail above. This table organizes all the information in the interview and highlights some of the significant statements for each description of a situation/transaction. The emphasis in organizing the information instead is to demonstrate the unity of the themes describing a particular situation/transaction.

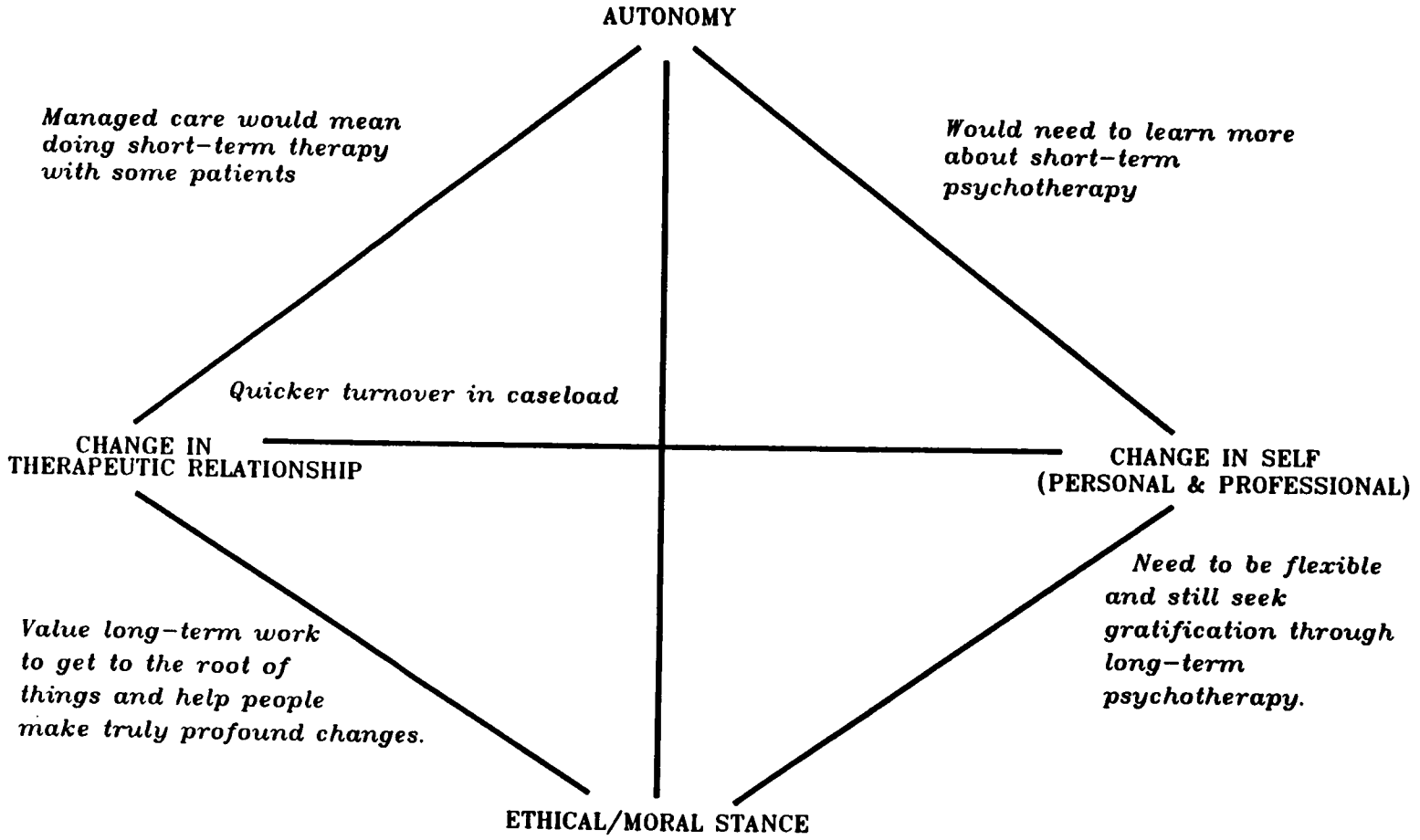


Figure 11. PARADIGM CASE (Participant #7): Situation/transaction #9: Doing short and long-term psychotherapy and a changing professional identity

Table 2: PARADIGMATIC CASE ANALYSIS -- Thematic configurations for Participant #7.

Participant #7 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
RESPONDING TO COMMUNICATIONS FROM MANAGED CARE REVIEWERS	Feel intruded upon. Realize my practice is not as autonomous as it used to be.		Feel anger. Become reactive. Feel rage, then become modulated and get more productive. Feel resentful and then move to a more balanced view.	Motives of reviewers oriented only to money. Reflect on limited money available for psychotherapy and that there must be criteria for distributing the resources.
COMPLETING MANAGED CARE REVIEW FORMS		More accountable to patient. Discuss forms with patient. Patient has positive reaction because they have written evidence of my thoughtfulness and concern.	Modulated anger and resentment. Filling out forms helps organize clinical thinking.	Modulate in order to be an effective advocate for patients. Concern to be truthful without betrayal of confidentiality.
PROCESSING RELEASE OF INFORMATION FORMS WITH FAMILY.	Increased awareness of presence of third or fourth party	Process patient's feelings about presence of a third party	Feel resentful. Gets modulated before discussing release form with patient.	Understands monitoring as decisions about distribution of insurance money
RESPONDING TO MANAGED CARE'S IMPACT ON PROFESSIONAL PEERS	Times when most aware of the impact of managed care. Felt intrusiveness upon others. Arbitrariness of reviews.		Felt anger and resentment. Felt fortunate about being able to plan ahead to deal with managed care. Talked with colleagues about decision–making.	
PERSONAL RESPONSIBILITY AND THE RESPONSIBILITY OF PROFESSIONALS	Sense of intrusion.		Move past initial sense of rage and superiority to reviewers. Become modulated and feel sense of personal responsibility. Feel better about oneself when being modulated. Responsible for deciding to remain involved with third party players.	Personal responsibility to distribute money for psychotherapy. Responsibility to accept scrutiny, if accept insurance reimbursement. Conscientiously justify need for long–term treatment.

Table 2: (continued)

Participant #7 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
INTEGRATED MONETARY ISSUES IN THE THERAPEUTIC PROCESS.	Third-party reimbursement allows therapist to avoid certain responsibilities and decisions.	Taking full fee directly from patient would better integrate monetary issues in treatment process. Potential change in caseload.	Increased responsibility and burden of managing payments directly. Decisions about readjusting fees for specific clients.	Deciding which segment of the population should be my clients.
ANTICIPATING LOWER FEES AND INCOME	Not participating with third-party reimbursers would mean lower fees and income. Insurers will pay less in any case.	Patients would be more responsible for their fee.	Affects major life decisions, including where to live.	
RESPONSIBILITY TO EDUCATE THIRD-PARTY REIMBURSERS	Managed case reviews provoke a confrontation with personal responsibility in an intrusive and arbitrary way.		Balance patients needs and own needs regarding time to fill out managed care review forms. Responsible to patient and society to fill out forms conscientiously. Not optimistic about efforts to educate third-parties. Feels rage about being confronted with personal responsibility.	Professions should educate third-parties about need for long-term treatment.
DOING SHORT AND LONG-TERM PSYCHOTHERAPY AND A CHANGING PROFESSIONAL IDENTITY	Managed care would mean doing short-term psychotherapy with some patients.	Mixing short and long-term psychotherapy. Quickens turnover in caseload.	Would need to learn more about short-term psychotherapy. Being flexible and still seeking gratification through long-term treatment.	Being a patient in long-term psychotherapy has been valuable. Value long-term work to get to the root of things and help people make truly profound changes. Long-term psychotherapy is not good for everyone.

Comparing Participants

In this section interviews for all ten participants are summarized. A short description of the salient features of each participant's interview is presented. This is followed by a table that provides a thematic analysis of each of the situation/transactions described by the participant. The same tabular format used to summarize paradigm case is also used for all other participants. Text in tabular cells use significant statements from each participant and, when possible, their own words. Although there is some rephrasing, essential meanings have been retained. In narrative summaries that precede the relevant table, I have taken somewhat greater liberty in rephrasing participant statements. For example, Participant 1 stated that he "feels unable to affect managed care policies" but there was also evident a tone of helplessness along with this statement of frustration in regard to his state professional organization. When inferences are introduced about a participant's experiences or concerns they are introduced in the summary by "it appears that...". The salient themes for each situation/transaction are described in Subsection B Thematic Analysis.

Thematic Configurations for Individual Participants

Participant #1

A. Narrative description: This participant spoke mainly about the difficulties involved in starting up a full-time private practice because of the predominance of closed panel provider networks (PPOs) in the local community. This participant discussed the difficulties of becoming a member

of these closed panel networks. This participant stated that this has clearly has an impact on her/his ability to make a living. S/he expressed frustrating with the activities of her/his professional organization. A sense of helplessness also was evident in her/his statement that professional organizations give up control to the arbitrary policies of managed care and do not protect the interests of their members in an equitable way.

It appears that this participant's believes the opportunity to become a member in a PPO should be based on educational criteria or other criteria relating to specialized training and skills rather than to the economic needs of managed care companies. These (economic) criteria presumably attempt to the restrict the pool of providers within a geographic region so that the insurer is able to limit utilization of mental health services and reap discounted fees from panel providers.

S/he spoke to the different types of review experiences s/he has had while being part of an HMO/IPA network at an outpatient hospital clinic. S/he felt that an important distinction in her/his experience with managed care reviews were whether they were done by clinicians associated with the hospital or done by external reviewers. S/he expressed particular concern about issues of confidentiality. S/He discussed several patients cases very briefly in terms of these issues. S/he chose to discuss one clinical case in greater detail and described how the limitations in the number of sessions covered by the patient's insurance affected the treatment process and her/his own sense of the clinical work.

B. Thematic Analysis: The thematic analysis of the situation/transactions for Participant #1 is presented in Table 3. This participant's interview is divided into four situations/transactions. In the first situation/transaction, the theme of *autonomy* became salient because of the impact of managed care on this participant's ability to make a living through the independent practice of psychotherapy. Some of the significant statements concerning the relationship to professional organizations blend together the themes of *change in self* and *ethical / moral stance*. In the second situation/transaction this Participant experienced change in her/his clinical autonomy depending upon whether the managed care review was done by a colleague at the hospital based clinic or by a reviewer external to the clinic. Difficulties posed by external reviews were discussed in relation to the themes of *change in therapeutic relationship* and *change in self*.

The third situation/transaction involved concerns about confidentiality and the release of information to managed care reviewers. Issues related to the themes of *change in therapeutic relationship* and *change in self* were figural. This participant reflects on feelings about his/her own personal care in an HMO/IPA model and how this relates to his/her handling of issues of confidentiality in the therapeutic relationship. In the fourth situation/transaction the effects of limited benefits of an HMO/IPA model are discussed in terms of a specific patient's care. The themes of *change in therapeutic relationship* and *change in self* and *ethical / moral stance* are all figural in this case discussion. This participant spoke about difficult choices involving therapeutic technique and basic value conflicts with managed care.

Table 3: Thematic configurations for Participant #1

Participant # 1 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
DIFFICULTY BECOMING AN IPA OR PPO PROVIDER	Unable to become an IPA or PPO provider. Unable to get patient referrals as a result. Impacts on ability to make a living.		Feels unable to affect managed care policies. Feels frustrated that professional organizations give up control to arbitrary policies of managed care. Would feel vulnerable without part-time work in an outpatient hospital clinic.	Professions or licensing boards do not determine provider status. This is arbitrarily determined by IPAs and PPOs. Professional organizations give up control to third parties resulting in poor quality of care. Psychologists need to stand together to work equitably with third parties.
REACTIONS TO MANAGED CARE REVIEWS IN AN OUTPATIENT HOSPITAL CLINIC	In-house reviewers did not affect treatment. Outside reviewers limited benefits arbitrarily.	A patient's co-payment will probably lead to decision to terminate. Errors and confusion in hospital billing must be discussed in treatment.	Increased effort to provide information to reviewers. Do not understand reviewer's reasoning. Must straighten out billing problems between patient, hospital and third-parties.	
REACTIONS TO A PATIENT'S CONCERNS ABOUT CONFIDENTIALITY		Tell patient that reviewers and primary care physician will have access to psychiatric diagnosis and other significant information. Patient terminated because of this but most are not concerned about confidentiality or are in denial about it.	Would not want reviewers or primary care physician to know one's own diagnosis.	
TREATING A DEPRESSED PATIENT WITHIN ANTICIPATED 20 SESSION LIMIT		Insurance benefit limits force a more problem oriented and less psycho dynamic approach. Focus on day to day functioning rather than affective experience (related to significant losses).	Sense of urgency because patient will leave after 20 sessions. Feel that being empathic rather than pragmatic is better. Straddling two different models creates confusion in clinical orientation.	Feel obligated to work within patients' insurance benefit time limits. Deeper issues relating to early losses will go untouched. She is quite defended around these issues and it would take a long time to reach them.

Participant #2

A. Narrative description: This participant portrayed her/himself as actively engaged with a number of managed care companies. S/he did not mind being reviewed by outside reviewers but felt strongly that reviewers should be professional peers. S/he indicated that in the cases s/he chose to discuss s/he was very successful at convincing reviewers to approve treatment. This participant also described her/his specialty in the treatment of gender disorders and the advantages and disadvantages that this specialty posed in becoming a provider for closed panel PPOs. S/he tended to discuss specific clinical cases by focusing on patient reactions to managed care rather than to the impact on her/himself. This participant was concerned about struggles between managed care companies and therapists over the ability to access needed treatment, and the responsibility and liability for patients who were at risk to harm themselves or others. Issues related to informed consent were raised in this context. S/he believed that it is important to design a system where providers and payers share equal accountability for patients' actions.

B. Thematic Analysis: The thematic analysis of situation/transactions for Participant #2 is presented in Table 4. This participant's interview is divided into five situations/transactions. The first situation/transaction involved the discussion of a specific case. This discussion also incorporated general comments on the participant's experiences with reviewers having varying levels of professional training and blended the themes of *autonomy*, *change in therapeutic relationship* and

Table 4: Thematic configurations for Participant #2.

Participant #2 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
TREATMENT OF A FEMALE CLIENT IN INDIVIDUAL AND COUPLES THERAPY	Managed care reviewer covered services since treatment had ended. Managed care is not being done by professional peers.	Explained need for couples therapy and it was reimbursed, even though it was not on list of covered services.	Do not mind being reviewed but feel strongly that review should be done by professional peers.	
MANAGED CARE'S CONCERNS ABOUT THE TREATMENT OF TRANSSEXUALS AND GENDER ISSUES	Some reviewer's level of resistance to or ignorance of the treatment of transsexuals is remarkable. Some managed care staff understand costs and benefits of treating these disorders.	Some of my patients with gender disorders and multiple diagnoses are stabilized in long-term once per week psychotherapy.	Some PPOs have not accepted me as a provider because of a specialization in gender issues. Some other PPOs have wanted me to join because of this specialty.	Once per week psychotherapy is a low cost alternative to medical and inpatient psychiatric costs and to the consequences of the patient's potential self-destructive behavior.
PATIENTS' REACTIONS TO MANAGED CARE, INCLUDING TRANSFERENCE REACTIONS		Patients' anxiety and grumpiness about managed care has intensified in the last couple of years. Some patients develop transference reactions involving wishes to protect the therapist or believe therapist and third-party are allied against them.		
PATIENTS ASK THERAPIST TO LIE TO INSURANCE COMPANY		Discuss issues related to lying for the patient and lying to the patient in the session. Discuss fraud and therapist's legal liability in the session. Use confrontation about patients sense of entitlement.		
MANAGED CARE'S IMPACT ON INFORMED CONSENT AND ACCOUNTABILITY FOR PATIENTS	Managed care struggles over who is accountable for patients who are a risk to self or others. Could talk yourself out of a job trying to deal with informed consent.	Discuss the requirements of informed consent in the session. Was able to get a depressed patient hospitalized even though they were not psychotic or acutely suicidal.	Sympathetic to managed care's and therapist's concerns about accountability for patient's actions.	Design a system where accountability is evenly spread throughout the system. Do not leave some parties with a lot of responsibility for patients' actions and no power.

change in self. In the second situation/transaction this participant discussed his/her specialization in the treatment of gender disorders and how PPOs have reacted to this specialization. Each of the themes was present in this discussion, which involved general comments and specific clinical case material. The third and fourth situations/transactions focused on transactions with specific patients and emphasized the theme of *change in therapeutic relationship*. The fifth situation/transaction was more wide ranging in its focus and the participant integrated concerns about informed consent and the way that managed care affects therapists' liability for their patients' behaviors; the discussion involved all four themes.

Participant #3

A. Narrative description: This participant felt that some aspects of managed care are helpful and some harmful. Managed care is helpful because it reminds clinicians, especially psychiatrists, that specific treatment goals and plans are important. This participant felt strongly that s/he does not like to be forced by managed care to provide a diagnosis for a patient. S/he cast this issue in terms of an ethical dilemma between being truthful and doing no harm to the patient. Therapists may choose to resolve this issue by putting down a milder diagnosis than might seem warranted. It appears that this participant was concerned that if the diagnosis had to be revised at a later time, the therapist's judgement could be questioned and s/he could then be at some financial or legal risk. This participant then began to raise issues of confidentiality and discussed her/his decision to give some patients a role in deciding which diagnosis would be provided to a third-

party. S/he discussed the advantages and disadvantages of a particular HMO/IPA model which provided a standard 20 session outpatient psychotherapy benefit. S/he felt that this benefit plan offered a greater number of sessions to patients than traditional indemnity plans with yearly dollar caps on outpatient services. This participant felt that therapists had sufficient flexibility with this benefit plan to adapt treatment plans to individual patient needs. S/he described the types of patients that could appropriately respond to such alterations as "intermittent treatment". This participant also discussed her/his practice of setting different fees with individual clients. The values and personal conflicts involved in this decision making and its potential effect on the therapeutic relationship was discussed in detail.

B. Thematic Analysis: The thematic analysis of situation/transactions for Participant #3 is presented in Table 5. This participant's interview divided into five situations/transactions. In the first situation/transaction this participant discussed her/his general experiences with managed care in a manner that integrated all themes. This participant developed a more focused discussion around issues of confidentiality and providing diagnoses to third or fourth parties in the second situation/transaction. This discussion primarily related to themes of *autonomy* and *change in therapeutic relationship*. In the third situation/transaction, a set of general comments on HMO/IPA managed care plan is discussed primarily in terms of the theme of *ethical / moral stance*. In the fourth situation/transaction, this participant describes the ways in which s/he adapts therapeutic techniques to the structures of an HMO/IPA benefit

Table 5: Thematic configurations for Participant #3.

Participant #3 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
SOME ASPECTS OF MANAGED CARE REVIEW ARE HELPFUL AND SOME ARE POTENTIALLY HARMFUL	Defining early treatment goals is helpful. Do not like being forced to share a diagnosis with third parties. There is a tendency to put down a milder diagnosis at first.	Even without managed care I was probably setting early treatment goals compared to my peers. Early goals are set and level and depth of work can be changed later on.	There is a tendency for psychiatrists .to forget that they are doctors - to forget that treatment goals are important.	In psychiatry there is a conflict between determining an accurate and truthful diagnosis and an equally compelling obligation to do no harm. Sharing information with third parties may harm the patients interests. Putting down a milder diagnosis is not in the doctors interest if it must be revised to justify continued payment for treatment.
DISCUSSING DIAGNOSIS AND ISSUES OF CONFIDENTIALITY WITH A PATIENT	There is no control over the confidentiality of that part of the record given to the insurance company.	Gives some patients a role in deciding what diagnosis will be presented to a third party. Discusses the implications of diagnosis for future insurance coverage.		
COMMENTS ON 20 SESSION HMO/IPA BENEFIT PLAN	Working within a 20 session IPA/HMO benefit plan.		Mixed feelings about various benefit plans.	Managed care is not concerned about clinical prevention except for costs of care. Unsure if it is good to have open-ended benefits. Graduated co-payments in a 20 session benefit is a good plan. It is clinically reasonable for short-term crisis work or introducing value s of longer treatment. A 20 session plan is better than a plan with a yearly dollar cap because therapists increase their fees and reduce benefits.

Table 5: (continued)

Participant #3 Situation/Transaction	Threat to Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
ADAPTING TREATMENT PLANS TO 20 SESSION HMO/IPA MODEL	Working with an HMO/IPA benefit plan.	For patients with object constancy altered treatment strategies include: intermittent therapy, massed sessions several times per year, homework, stretch out number of sessions by having short sessions.	Caught by surprise when some patients drop out of treatment when co-payment begins. If knew this at start, would have done treatment differently. So now make a treatment plan with patient at start based on financial resources.	Intermittent treatment does not work for patients who do not have object constancy.
PROCESS OF SETTING DIFFERENT FEES FOR INDIVIDUAL PATIENTS		Discuss setting fees in explicit and individually tailored way. It demystifies the financial part of treatment. Other therapists who only accept the full fee from their patients directly each session get transference reactions around money. Some patients still show transference reactions around co-payments.	Discussing and verifying a patient's financial resources still seems brutal. Being blunt and practical about money probably means transference working through is more difficult and less available for my patients. With co-payments patients reactions are less threatening to them and to me.	Reserve the right to pass judgment about a patient's extraordinary expenses in reducing a fee. Have a quota for number of reduced fees. Being blunt and practical is better than having patients act out transference and stomp out of therapy and feel abandoned at session 20.

plan. The theme of *change in therapeutic relationship* is most prominent but the discussion also integrates themes of *change in self* and *ethical / moral stance*. This participant discussed issues concerning setting fees with patients in the a manner that blended themes of *change in therapeutic relationship, change in self* and *ethical / moral stance*.

Participant #4

A. Narrative description: This participant mainly described the impact of managed care in the context of an involvement with one national PPO managed care plan and several clinical cases became the focal point for discussion. This participant felt that managed care had a uniformly pernicious impact on treatment. S/he described the effects of treatment plan reviews in a way that provided a detailed interweaving of the impact of the reviews on the therapeutic relationship, of her/his feelings in response to the review process, and of the value conflicts with managed care.

B. Thematic Analysis: The thematic analysis of situation/transactions for Participant #4 is presented in Table 6. This participant's interview divided into four situations/transactions. This participant explores three specific clinical cases in each of the first three situation/transactions. Each of the themes is integrated in the first two clinical case discussions. The discussion took a more narrow focus in the third situation/transaction and described a specific instance where managed care restricted the participant's clinical autonomy and curtailed treatment. The fourth situation/transaction gathers together a range of set of general comments that occur throughout the interview and refers back to or elaborate

Table 6: Thematic configurations for Participant #4.

Participant #4 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
WORKING WITH AN ADOLESCENT PATIENT WITHIN A PPO	This PPO used case managers. The case manager contacted the family before contacting me and advised other treatment alternatives.	I had been working with a 15 year old adolescent for several years. She was first seen for conflict with her mother, school problems and running from home. Patient's relationship with her mother and her behavior had improved. After case manager contacted family patient became pregnant and treatment was terminated. (inference that patient felt relationship would be snatched away and she acted out)	Managed care is one of the most pernicious forces that I have encountered. Furious about case manager's intervention.	Purported aim of managed care was to distribute services more effectively. Case managers intervention led to a tragic outcome.
WORKING WITH A PATIENT WITH A DISSOCIATIVE DISORDER WITHIN A PPO	Case management reviewers.	Patient was being treated for dissociative episodes and eventually they were only occurring within the sessions. Patient's daily functioning was improving. Reviewer took the position that if sessions were terminated the problem would be gone. There is a primitive logic to that judgment.	Reaction to this review process was utter despair and fury.	Managed care's failure to understand the process of psychotherapy is awesome. If I help this patient to understand his dissociative process, he may become more attached to me. If psychotherapy is snatched away, it will be destructive to him. The uncertainty in the therapeutic relationship means that no meaningful work can get done.
WORKING WITH A PATIENT WITH A BORDERLINE PERSONALITY DISORDER WITHIN A PPO	Case management reviewers. Reviewer said that given the diagnosis there is not much you can do in this case so taper off the sessions and get the patient into a lower level kind of treatment like a support group.	During a period of acute distress this patient refused a hospital admission. She began sessions several times per week in order to prevent a hospitalization.		

Table 6: (continued)

Participant #4 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
REVIEW PROCESS IN THE PPO AND DECISION TO RESIGN FROM THE PPO	Review process was intrusive. Telephone reviews were required every few sessions on each patient. Review criteria were considered proprietary and were not disclosed to the providers.	Disruptions that are generated by the patient are part of the therapeutic process and are workable. Case management disrupts the therapeutic relationship. I advise patients that they cannot depend on their insurance benefits. Patient's reactions to this show up as transference but it is less constructive. Third-party benefits with a yearly dollar cap are less disruptive to treatment.	Resigned from this PPO because managed care presence was too disruptive to treatment. You could never anticipate a course of treatment or know when it might be terminated. Felt rage about having to go through a 15 minute to half hour phone call to review each patient. During the telephone reviews I don't dare be receptive to what is going on because reviewers will snatch treatment. This disrupts being receptive to the next patient in the next session.	Hypocrisy of managed care review criteria was infuriating. Outside reviewers are destructive and disrespectful. Reviewers were operating on a statistical model based on their own data. This was a catch-22. Reviewers decisions determined the statistical norm. Managed care is about the politics of money. The practice of psychotherapy is a realm that is sacred to me. It is taken very seriously because I have devoted my adult life to learning as much as possible about psychotherapy at great financial and emotional cost.

on this participant's decision to resign from a PPO. This discussion integrates each of the themes.

Participant #5

A. Narrative description: This participant described the impact of managed care as "chilling," and chose to discuss how a particular patients were affected. S/he described three specific cases in a fair degree of detail by focusing on changes in the therapeutic relationship. This participant stated that s/he is "not against managed care per se" but expressed considerable negative feelings and appraisals about his/her participation in a particular PPO. S/he also described involvement with a different managed care system, an open panel fee-for-service utilization review process. This participant experienced this latter review process as forcing a description of the treatment process and goals into more objective terms although it is described as a more positive experience compared to other forms of managed care. This participant also discussed her/his decision to provide free care to some patients when their PPO refused to authorize further payment. This participant gave a detailed description of her/his feelings and values about providing free care and assessed the impact of her/his own feelings on the therapeutic relationship.

B. Thematic Analysis: A thematic analysis of situation/transactions for Participant #5 is presented in Table 7. This participant's interview is divided into six situations/transactions. The first situation/transaction gathers together a general set of comments about participation in a PPO. This discussion integrates all of the themes. The following three

Table 7: Thematic configurations for Participant #5.

Participant #5 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
REACTING TO PARTICIPATION IN A PPO	Managed care says it supports long-term treatment but they do not do it practice. Other therapists on the panel find the review process was dishonest and they resigned.	While treating a severely disturbed patient and no results seen in three months reviewers said that referral to another therapist should be considered. If progress is reported, the reviewers question the need for further treatment.	Managed care has a chilling effect on long-term treatment. It was very frustrating working with this PPO.	Can understand the need for reasonable managed care and am not against it per se. This PPO did not value or understand long-term psychodynamic psychotherapy. 14 out of the 15 cases reviewed in this PPO were disastrous experiences. Treatment was ended in the middle and the patients were worse off as a result.
WORKING WITH AN ADOLESCENT PATIENT WITHIN THIS PPO	After I fought managed care's limits, some extensions on the length of treatment were granted but not enough time was given.	Patient had been successfully treated for depression in a prior episode of treatment lasting several years. Patient returned for treatment because of depression related to parent's divorce. Depression was related to losses and given managed care's limits and review process the patient was not going to reconnect to therapy in a safe and comfortable way.	I battled fairly aggressively with managed care reviewers. I enlisted the support of the parent in this battle with managed care.	
WORKING WITH A PATIENT WITH A PSYCHOSOMATIC DISORDER WITHIN THIS PPO	Review process put a limit on frequency of sessions. Managed care psychiatrist determined that biological treatment was needed rather than psychotherapy.	This patient made a small gain in treatment by becoming overtly rather than covertly angry. Disorder was related to anxiety about loss and separation. Treatment was terminated precipitously because of reviews. Patient left treatment with increased marital conflict and unresolved issues.	I made an effort to back up need for psychotherapy with a literature review but managed care reviewers did not change their judgment. This effort involved extra time and expense.	

Table 7: (continued)

Participant #5 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
WORKING WITH A PATIENT WITH A PARANOID DISORDER WITHIN THIS PPO	Reviewers declined continued coverage for psychotherapy.	Patient was making progress but reviewers decided that treatment was no longer necessary. When termination occurred paranoia was increasing because of an impending marriage and increased demands for intimacy.	I had an outside consultant evaluate patient and support the need for treatment.	
REACTING TO OPEN PANEL FFS MANAGED CARE UTILIZATION REVIEWS	Reviewers ask you to document and clarify your goals, describe the treatment process and explain why treatment is appropriate.		So far this review process has been reasonable. It has allowed me - practically forced me to be more objective about what I am doing and describe it clearly. This is positive. The time it takes away from clinical work is still very difficult.	Can understand the need for managed care when done in a reasonable way.
SETTING REDUCED FEES WITH PATIENTS AND PROVIDING FREE CARE		If I have too many free care patients it has got to introduce some unconscious negative response in me. Once and awhile I get a signal that resentments build up with some patients who have altered fees. Have to be real careful not to dump resentments onto the patient.	Continued treatment with some PPO patients even though I was not eligible for reimbursement and I provided free care. Appreciate seeing patients improve when I have built up a relationship with them. Do not have a problem applying free care with patients when I choose to do it at the start of treatment. It can be worked out as part of the therapeutic alliance.	With some PPO patients I felt that continuing treatment was the ethical and responsible thing to do. Managed care's decisions do not match those patients that I think would need or benefit from treatment. I am sensitive to those patients who would benefit from altered fees given my own life experiences.

situations/transactions describe how this participation in a specific PPO adversely affected treatment in three individual cases. This participant integrates the themes of *autonomy*, *change in therapeutic relationship*, and *change in self* in her/his discussion of these cases. The fifth situation/transaction involves a discussion of a different form of managed care review and serves as a point of contrast to the other situation/transactions. In the final situation/transaction this participant describes how s/he sets reduced fees with various patients. This discussion is presented in a series of general comments that blend the themes of *change in therapeutic relationship*, *change in self*, and *ethical / moral stance*.

Participant #6

A. Narrative description: This participant mainly described the ways that s/he works to ensure that managed care will only have a minimal effect on the therapeutic relationship. S/he expressed very strong views on conflicts between the medical model used by managed care and his/her own set of values regarding the practice of psychotherapy. These concerns were expressed mainly in terms of values and beliefs and did not incorporate a detailed discussion of specific patients. This participant was able to limit the impact of managed care on her/his practice of psychotherapy by reckoning with patient finances at the start of treatment. This participant chooses to begin a treatment relationship with only those patients who would be continued in treatment regardless of third-party insurance. This means that this participant selects patients based on the number of patients that s/he is comfortable carrying at a reduced fee at any given point in time. S/he

described the personal feelings and value conflicts associated with this set of decisions.

B. Thematic Analysis: The thematic analysis of situation/transactions for Participant #6 is presented in Table 8. This participant's interview divided into four situations/transactions and the participant's discussion was conducted at a general level for all situation/transactions. The tabular representation of these experiences is fairly condensed relative to other participant's because s/he described a limited range of experiences with managed care and a single consistent strategy. The first and second situation/transactions were discussed with a focus on the self. This participant reflected on the setting fees and other financial arrangements with patients in the third situation/transaction. This discussion integrated the themes of *change in therapeutic relationship*, *change in self*, and *ethical/moral stance*. In the final situation/transaction, this participant explored basic value conflicts with managed care; this discussion integrated all of the themes.

Participant #7

A. Narrative description: This participant's interview was presented as the paradigm case in Section 1 of this chapter. Some salient experiences and concerns will be reviewed here for the sake of comparison with all interviews. This participant began the interview by describing a set of experiences involving communications with managed care organizations about specific cases. This participant then described how s/he first became

Table 8: Thematic configurations for Participant #6.

Participant #6 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
AWARENESS OF MANAGED CARE AS BACKGROUND NOISE		Does not impinge on treatment process. I tell them you will be getting a certification notice in the mail.	Managed care is a background noise, an awareness of having to seek recertification after a specific number of sessions. The presence of managed care becomes more salient when a review form needs to be written. It is a relief to when managed care is over.	
PROCESS OF WRITING THE REVIEW FORMS	Reviewers have not disagreed with the requests but I expect that will happen in near future.		Forces me to be more concrete in my thinking and more prescriptive in the write-up. The issue is how to adequately represent my own thinking about the therapy process and reconcile that with the financial motivations of managed care.	
RECKON WITH PATIENT'S FINANCES AT THE START OF TREATMENT		Choose patients so that constraints of their finances is not a factor in the treatment process. Will not start with a patient if their third-party insurance will not cover the expected length of treatment and I cannot provide free care or a reduced fee.	Suspect that professionals do not provide free care as often as some ideal might suggest. There is some conflict in me about living up to my ideals.	Once I start treatment I will not terminate with the patient because they cannot pay my full fee. My agenda is being with the patient as long as they want. I reckon with my financial needs so managed care does not get in the way.
CONFLICT WITH MANAGED CARE'S MEDICAL MODEL	Managed care proceeds from a medical model, a mechanistic view. Managed care's limits and caps assume we can predict and control in psychotherapy.	Can't predict how long treatment will last.	Glad when managed care is out of the picture and plan for when it will be out of the picture.	Some ways of being are better and right. Reality of helping human beings, real helping, takes time.

aware of managed care through seeing the impact it was having on professional peers. A concern with personal and professional responsibility was present throughout much of the remainder of the interview. In the latter part of the interview, this participant reflected on ways that managed care might have an impact on her/his future professional identity and personal life choices.

B. Thematic Analysis: The thematic analysis of situation/transactions for Participant #7 is presented in Table 9. This participant's interview is divided into nine situations/transactions. These situation/transactions were discused in detail in the discussion of the paradigmatic case analysis.

Participant #8

A. Narrative description: This participant, who specializes in the treatment of eating disorders began the dialogue with a focus on the way in which managed care has affected her/his treatment of patients with such disorders. S/he felt that it had not been difficult to obtain authorization for inpatient psychiatric admissions for these patients from managed care reviewers. This participant went on to describe feelings and values about providing free care or reduced fees to specific patients. In this context s/he emphasized a sense of providing free care in order to give something back for her/his education and training. S/he also commented on the ways that managed care would affect her/his involvement with partners in a group private practice if they collectively became associated with a closed panel provider network. Overall, this participant felt that her/his experiences with

Table 9: Thematic configurations for Participant #7.

Participant #7 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
RESPONDING TO COMMUNICATIONS FROM MANAGED CARE REVIEWERS	Feel intruded upon. Realize my practice is not as autonomous as it used to be.		Feel anger. Become reactive. Feel rage, then become modulated and get more productive. Feel resentful and then move to a more balanced view.	Motives of reviewers oriented only to money. Reflect on limited money available for psychotherapy and that there must be criteria for distributing the resources.
COMPLETING MANAGED CARE REVIEW FORMS		More accountable to patient. Discuss forms with patient. Patient has positive reaction because they have written evidence of my thoughtfulness and concern.	Modulated anger and resentment. Filling out forms helps organize clinical thinking.	Modulate in order to be an effective advocate for patients. Concern to be truthful without betrayal of confidentiality.
PROCESSING RELEASE OF INFORMATION FORMS WITH FAMILY.	Increased awareness of presence of third or fourth party	Process patient's feelings about presence of a third party	Feel resentful. Gets modulated before discussing release form with patient.	Understands monitoring as decisions about distribution of insurance money
RESPONDING TO MANAGED CARE'S IMPACT ON PROFESSIONAL PEERS	Times when most aware of the impact of managed care. Felt intrusiveness upon others. Arbitrariness of reviews.		Felt anger and resentment. Felt fortunate about being able to plan ahead to deal with managed care. Talked with colleagues about decision–making.	
PERSONAL RESPONSIBILITY AND THE RESPONSIBILITY OF PROFESSIONALS	Sense of intrusion.		Move past initial sense of rage and superiority to reviewers. Become modulated and feel sense of personal responsibility. Feel better about oneself when being modulated. Responsible for deciding to remain involved with third party players.	Personal responsibility to distribute money for psychotherapy. Responsibility to accept scrutiny, if accept insurance reimbursement. Conscientiously justify need for long–term treatment.

Table 9: (continued)

Participant #7 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
INTEGRATED MONETARY ISSUES IN THE THERAPEUTIC PROCESS.	Third–party reimbursement allows therapist to avoid certain responsibilities and decisions.	Taking full fee directly from patient would better integrate monetary issues in treatment process. Potential change in caseload.	Increased responsibility and burden of managing payments directly. Decisions about readjusting fees for specific clients.	Deciding which segment of the population should be my clients.
ANTICIPATING LOWER FEES AND INCOME	Not participating with third-party reimbursers would mean lower fees and income. Insurers will pay less in any case.	Patients would be more responsible for their fee.	Affects major life decisions, including where to live.	
RESPONSIBILITY TO EDUCATE THIRD-PARTY REIMBURSERS	Managed case reviews provoke a confrontation with personal responsibility in an intrusive and arbitrary way.		Balance patients needs and own needs regarding time to fill out managed care review forms. Responsible to patient and society to fill out forms conscientiously. Not optimistic about efforts to educate third-parties. Feels rage about being confronted with personal responsibility.	Professions should educate third-parties about need for long-term treatment.
DOING SHORT AND LONG-TERM PSYCHOTHERAPY AND A CHANGING PROFESSIONAL IDENTITY	Managed care would mean doing short-term psychotherapy with some patients.	Mixing short and long-term psychotherapy. Quickens turnover in caseload.	Would need to learn more about short-term psychotherapy. Being flexible and still seeking gratification through long-term treatment.	Being a patient in long-term psychotherapy has been valuable. Value long-term work to get to the root of things and help people make truly profound changes. Long-term psychotherapy is not good for everyone.

managed care reviews have, up to the present, not had an adverse effect on her/himself or on her/his patients. This participant sensed that this would change and expressed concerns that managed care will become more intrusive and entail significant changes in the her/his mode of treatment and in her/his sense of professional identity.

B. Thematic Analysis: The thematic analysis of situation/transactions for Participant #8 is presented in Table 10. This participant's interview divided into six situations/transactions. The first situation/transaction focused on a *change in therapeutic relationship* involving the treatment of patients with eating disorders. The second situation/transaction involves a discussion of two cases in which this participant chose to provide free care, this discussion integrated all of themes. In the third situation/transaction, this participant described the potential impact of managed care on a specific clinical case. This discussion focused on the theme of *change in therapeutic relationship*. In the fourth situation/transaction this participant discusses how joining a PPO might affect his/her day to day working arrangements in a joint practice. The themes of *change in therapeutic relationship* and *change in self* were blended in this discussion. The fifth situation/transaction related experiences with case management of a specific difficult-to-treat patient. These experiences touched on the themes of *autonomy*, *change in therapeutic relationship*, and *change in self*. This participant discussed some anticipations about the future impact of managed care. These concerns were discussed at a general level and blended the themes of *change in self* and *ethical / moral stance*.

Table 10: Thematic configurations for Participant #8.

Participant #8 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
HOSPITALIZING PATIENTS WITH EATING DISORDERS	Required pre certification review for hospitalization.	Patients were referred because they were treatment failures. There was compelling evidence for hospitalization so they were accepted.		These patients needs for hospitalization were overwhelming.
PROVIDING FREE CARE WHEN THIRD-PARTY RESOURCES WERE EXHAUSTED	Patient's third-party coverage has a yearly dollar cap.	Continued treatment with two patients in a private practice after leaving a hospital setting. These patients had been in treatment for years. Despite their severe disorders they formed good working relationships. Treatment improved these patients lives.	Not willing to give up good working relationships in these cases. Might feel differently about providing free care if free care was given to a patient who wasn't doing much in treatment.	This is an ethical issue because these patients might not get care if I did not continue with them. These patients make special efforts to continue treatment so I am willing to give free care. This is a dilemma because I need to earn a living but also feel strongly about giving something back for my training and education.
WORKING WITH A HIGH FUNCTIONING PATIENT UNDER MANAGED CARE REVIEW	Managed care approved an initial 12 sessions with the possibility to apply for an extension.	Patient started treatment in marital therapy and shifted to individual treatment because of anxiety symptoms. If patient were to only plan to attend 12 sessions the treatment would have to be refocused. Patient has the means to pay the full fee so she will probably continue treatment.		

Table 10: (continued)

Participant #8 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
DECIDING WITH OTHER PARTNERS IN A GROUP PRACTICE WHETHER TO JOIN A PPO		Would be required to provide 24 hour crisis screening coverage in an emergency room for specific population. Frequent consultation would be required with managed care case managers for psychotherapy services.	Joining a PPO would mean compromises in our fees. I would not want to do 24 hour screening but partners in group practice may feel differently. Would feel that the psychotherapy would be shared with a silent partner (the case manager).	
WORKING WITH A PATIENT WITH AN EATING DISORDER UNDER MANAGED CARE	Patients insurance has a high lifetime benefit cap. Case manager reviews treatment plans.	Patient has a severe eating disorder. She has had psychotherapy, hospital and half-way house services.	Working with this case manager has been a reasonable experience because no reasonable treatment proposal has been rejected. Initially felt antagonistic toward case manager.	
ANTICIPATING GREATER IMACT OF MANAGED CAREON PRIVATE PRACTICE WORK			Have not been in a situation where managed care reviews have seriously affected treatment but feel it would undermine one's authority. Forsee managed care becoming more intrusive. Will have to learn to do short-term focal therapy. Sense of professional work would change.	Sort-term treatment does not take the place of a sustained treatment relationship. It is not cost effective. Therapy is all about a sustained relationship where someone grows over time and ther is no way to rush that.

Participant #9

A. Narrative description: In the initial description of an experience with managed care this participant was aware of a change in the forms of managed care over the past several years. S/he discussed her/his own difficulty in finding a DSM III-R diagnosis that would accurately describe her/his patients. This participant described times when s/he was able to convince a psychiatrist reviewer to allow claims based on her/his discussion of presenting problems and prognosis. These particular discussions occurred in a managed care context of utilization review of fee-for service reimbursement. This participant went on to contrast experiences with this form of managed care to recent experiences with a PPO. This PPO is a national chain that operates on a ten session model with strict guidelines. This participant was quite concerned about the negative effects of this type of managed care model, and felt it to be a more intrusive form of managed care. S/he discussed the impact of this model on her/his work with specific patients. This participant also described her/his reasoning about not reducing fees for patients whose third-party reimbursement is limited to closed panel HMOs and PPOs. S/he described how this decision poses an ethical dilemma when her/his current patients (and former patients seeking to resume treatment) have switched to a third-party insurer of this type. This participant was also concerned about the ways in which the professional organization had not demonstrated the cost effectiveness of psychotherapy.

B. Thematic Analysis: A thematic analysis of situation/transactions for Participant #9 is presented in Table 11. This participant's interview

Table 11: Thematic configurations for Participant #9.

Participant #9 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
COMMUNICATING WITH MANAGED CARE REVIEWERS (OPEN PANEL FFS)	Difficulty communicating patients' needs in medical psychiatric terms.	Psychiatrist reviewer allowed claim based on discussion of case rather than the diagnosis. Review focused on presenting problems, clinical progress and prognosis.		Almost never find a diagnosis which fits patients so habitually use adjustment reaction.
WORKING WITH A PATIENT WITH SEXUAL ORIENTATION CONFLICT IN A TIME LIMITED PPO MODEL	Must determine focal problem that can be addressed in 10 session limit. If he was a risk to self or others he could get more sessions approved.	Focal problem became helping patient to view his sexual orientation as an open question and educate him about the difficulties of changing orientation. I told patient from the start how the case was being reviewed. Could see patient's face fall when told he only had five sessions remaining.		Patient needs a positive relationship in a way which is difficult to fit into managed care criteria. Patient is fortunate to get a therapist who would not try to convert his sexual orientation in ten sessions.
GENERAL EFFECTS OF HMO AND PPO MANAGED CARE SYSTEMS	As providers are excluded managed care has adverse effects. I have been excluded from some PPOs.	I will continue to see patients with a yearly dollar cap benefit plan and will readjust their fees when benefits are exhausted. Will not do this for patients in HMOs or PPOs in which I am not a member.	Like to do long-term treatment in an intermittent form. Will not reduce fees for current of former patients who have switched to HMOs or PPOs in which I am not a member. Encouraged other professionals to take similar actions.	Will not reduce fees for patients who have insurance plans that I am excluded from because it subsidizes an organization that is trying to put me out of business. This is an ethical dilemma when it involves former patients.

Table 11: (continued)

Participant #9 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
DIFFICULTIES PARTICIPATING IN A SPECIFIC PPO MODEL	This managed care organization indoctrinates you into their model. Must call and review case after the first session.	There is an expectation that therapy will be completed in ten sessions.	Feels like another clinician is looking over your shoulder. The reviewer has less experience than I do and I am irked by being supervised by a junior colleague.	
VALUES CONCERNING DIFFERENT TYPES OF THIRD-PARTY REIMBURSEMENT			Angry at the profession because they have not demonstrated the cost effectiveness of long-term treatment. I worry that certain PPO models will prevail because they have lower monetary costs.	Have never believed that the sicker the person is the more they deserve our help. Some people who are willing to undergo the pain and difficulty of psychotherapy are not considered to be deserving of long-term care by certain HMO and PPO criteria. Monetary aspects of managed care are taking over. I believe in managed care but it is not being done right because it is not based on (outcome) data. I believe the relationship is the most important part of psychotherapy.

divided into five situations/transactions. In the first situation/transaction, this participant described experiences with the utilization review of fee-for service cases. This discussion related to themes of *autonomy*, *change in therapeutic relationship*, and *ethical/moral stance*. This participant discuses the effects of a time-limited PPO model on the treatment of a specific patient. This discussion focused on the *change in therapeutic relationship*, but also related themes of *autonomy* and *ethical/moral stance*. In the third situation/transactions, this participant discusses the general effects of HMOs and PPOs on professional practice; all four of the themes were present in this discussion. This participant returned to the difficulties of working within a time-limited PPO model in the fourth situation/transaction. These general comments integrated the themes of *autonomy*, *change in therapeutic relationship*, and *change in self*. The fifth situation/transaction involved a general discussion of values pertaining to managed care. The themes of *change in self* and *ethical/moral stance* were present in this discussion.

Participant #10

A. Narrative description: This participant began the dialogue by commenting on the different forms of managed care based on the participants extensive experience with the spectrum of inpatient, residential, and outpatient psychotherapy services. S/he distinguished between "managed care" (defined as case management which aims to adapt benefits to individual patient needs) and "utilization review" (defined as monitoring done for cost-containment). The way this Participant defined these terms do not quite match the ways these terms are used in the literature, but such definitions

are noted here and retained in tabular form to represent the organization of this participant's experience.

This participant chose first to discuss her/his experience with utilization review of inpatient services. S/he described the relationship with managed care reviewers as "constant warfare." As a result, the inpatient staff adapted their clinical record keeping by emphasizing patient pathology. This participant went on to describe the ways in which this strategy conflicted with the ways that case managers conduct reviews, who evaluate the utilization of services from the standpoint of what set of treatments led to improved functioning rather to a review of acute symptomatology. This Participant experienced managed care reviews of her/his private practice psychotherapy as adversarial. S/he described the attitudes toward this review process and basic value conflicts with managed care. This participant also described, in detail, her/his feelings about the review process and how this affected the therapeutic relationship. Managed care reviews made the treatment of difficult patients with paranoid or borderline personality disorders even more difficult if not impossible. This participant reflected on the way in which these reviews may have contributed to premature terminations with some of these patients. This participant also discussed strong personal feelings about the failure of professional organizations to address the impact of managed care. S/he also described the mental health professions as becoming increasingly degraded and failing to maintain a commitment to excellence in its training and standards of practice.

B. Thematic Analysis: The thematic analysis of situation/transactions for Participant #10 is presented in Table 12. This participant's interview divided into six situations/transactions. Since this participant provides many details in the discussion of specific situations, I have attempted to incorporate this into the table. This participant discusses utilization review of inpatient services in the first situation/transaction; each of the four themes was integrated in this discussion. The different context of case management is discussed in the second situation/transaction, which is thematically similar to the first except there is no discussion of the impact on the self. The following two situation/transaction involve the impact of managed care this particpant's practice of outpatient psychotherapy with the third situation/transaction focusing on the thematic relationship between *change in self* and *ethical/moral stance* and with the fourth focusing on the thematic relationship between *change in self* and *change in therapeutic relationship*. The themes are blended in the final two situation/transactions. The fifth situation/transaction focuses mainly on the *change in self* as it is experienced when managed care intrudes on difficult-to-treat cases. In the sixth situation/transactions, this participant expresses her/his concerns about the professional response to managed care; this discussion focuses on the thematic relationship between *change in self* and *ethical/moral stance.*

Table 12: Thematic configurations for Participant #10.

Participant #10 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
REACTING TO THIRD-PARTY UTILIZATION REVIEW OF INPATIENT SERVICES	Strict standards applied to acute care hospitalization. Relations with reviewers were adversarial. Reviews done daily or weekly.	Patient needs to be acutely dangerous to self or others to be eligible for inpatient services. Inpatient stays have become shorter and shorter.	Frustrating to call reviewers repeatedly. Constant warfare with reviewers in which they would not disclose criteria of review and hospital staff would try to guess the criteria. Learned to slant documentation, not to lie but emphasize a fraction of the case, the patient's acute symptoms.	Many utilization review companies did not have clinical competence or integrity. Reviewers have a cost containment strategy.
WORKING WITH CASE MANAGERS AND FLEXIBLE BENEFIT PLANS IN AN INPATIENT SETTING	Managed care is not monolithic. There is a difference between utilization review and flexible case management plans. Case management reviews were done weekly.	Case management provided range of options, paying for a mix of inpatient, residential and outpatient services.		Mental health care benefits could go further and last longer under these plans. Reviewers were more interested in whether a patient was getting better.
WORKING WITH MANAGED CARE (UTILIZATION REVIEW) OF PSYCHOTHERAPY IN THE PRIVATE PRACTICE SETTING	Review process is adversarial.		More difficult to explain outpatient cases to reviewers. Does not pay to trust reviewers too much. I play games with myself when completing the review forms and feel uncomfortable that I have distorted or exaggerated - presented a fragment of the truth that makes the patient's functioning seem worse.	There is a question of how honest to be with reviewers. Reviews of outpatient practice are done to save money - to deny reimbursement.

Table 12: (continued)

Participant #10 Situation/Transaction	Autonomy	Change in Therapeutic Relationship	Change in Self	Ethical/Moral Stance
EFFECT OF MANAGED CARE REVIEWS ON PSYCHOTHERAPY PROCESS	Review process is adversarial	Do not show review forms to the patients. Wonder if patients would be surprised to see what was written about them. My decision not to discuss review process with patient results in self-monitoring within a session about how this affects the treatment process.	Feel dirty, angry, and guilty when I see the patient because I presented them as worse than they are to the reviewer. I resent the patient because I find myself blaming the patient for having put myself on the spot.	
AVOIDING DIFFICULT CASES AND PREMATURE TERMINATION WITH DIFFICULT CASES	Review process is adversarial.	Some cases are cut short by the effect of reviews on the treatment process. My antagonisms and resentments may have played a role in a multi-determined process leading to premature termination.	Find my patience with angry and attacking borderline or paranoid patients considerably diminished by having to explain them to reviewers. Regret that my feelings may have contributed to premature termination. There is a greater probability of experiencing self doubt in a private practice setting - a silent rebuke about why patients continue to need long-term psychotherapy. This is a projection.	Would say that consciously cutting short the case because of a difficult patient or difficult review process would be unethical. Feel that one should be able to do something for someone quicker than one actually can. Guilt over not being powerful enough to effect a miraculous transformation in the patient.
REACTING TO THE PROFESSIONS RELATIONSHIP TO MANAGED CARE		Legal challenges to managed care has resulted in greater reimbursement for inpatient services in individual cases.	Amazed at the number of professionals who want to go back to the good old days and only complain. My preference is to take legal challenges to managed care but other professionals have not responded to this approach. Sad about the future of the profession because it is becoming increasingly degraded.	Professional community has no sense of the outrageous costs of mental health services. Need to cut fees in an age of deflation and lower standards of living. Professions have been greedy. Should be prepared to lower fees and fight anyone who would take our patients away from us. There is no commitment to excellence and intensive training no longer matters.

CHAPTER IV

DISCUSSION

The purpose of this chapter is to relate the thematic structure of the psychotherapist's life-world concerning managed care to some of the background conceptual and meta-theoretical issues raised in the introduction. Allowing participants to explore, in an open-ended dialogue, whatever concerns about managed care were figural for them resulted in a wide range of topics and the scope and depth of these discussions has shaped the resulting thematic analysis as well as re-configured the overall conceptualization of the present research program. Two main questions emerged from considering the phenomenological results of the present set of interviews: first, what common concerns emerged among the ten participants?, and, second, how can these common concerns be presented in such a way as to reveal their relevance to the rapidly changing mental health delivery system?

In pursuing an answer to these questions, it became clear that the focus of the present study must shift to an analysis of the interplay between the personal and social dimensions of experience. A major task, then, became one of testing a series of analytic techniques -- primarily involving narrative re-construction -- that would serve to locate the nuances of participant experiences within the variable and uncertain social practice known as

managed care.

The results of this study have led me to place even greater emphasis on methodological issues than I had originally intended. To have impact on decision-makers in the mental health system, it is imperative to develop a methodological approach that relates to the language of systems and to the needs and interests of bureaucratic authority. Hopefully, the incorporation of concepts and methods from reflexive sociology can advance the empirical and critical potential of existential-phenomenology by demonstrating the way in which personal meaning is influenced by institutional contexts.

All of this is not to discount the relevance of the present thematic analysis of participant experiences to various parties within the mental health system. The description of psychodynamic psychotherapists' experience in the present study certainly has relevance for other psychotherapists in independent practice, regardless of theoretical orientation. A careful presentation of the array of impacts that managed care can have should serve an educative function for other psychotherapists.

The present set of experiential descriptions concerning the impact of managed care in the therapeutic life-world may also serve as a starting point for further discussion on such topics as quality of care, determination of clinical and policy criteria for persons needing long-term psychotherapy, the effect of third-parties on the therapeutic alliance, supervision of transference and counter-transference issues with respect to third-parties, and the relationship of personal moral values to professional codes of ethics. The present thematic analysis touches on many current and compelling issues in

mental health services precisely because it is an articulation of lived experience. As such, the present analysis is not confined by preconstructed and taken-for-granted conceptualizations in formal discursive fields.

It is, however, important to bear in mind that the present descriptions of personal experience are, from a critical hermeneutic perspective, also preconstructed; that is subject to the acceptance of concepts that dominate discourse in the mental health professions. Nevertheless, lived experience serves as the touchstone for any reconstruction of concepts to be used in formal discursive fields.

When presenting the paradigmatic case in Chapter III, I emphasized the manner in which the phenomenological structure discloses a dynamic configuration among experiential themes. Significant statements were placed, for the most part, between the major themes largely because many statements seemed to convey a blend of themes. It is also appropriate to situate formal concepts from the mental health discourses within an experiential space defined by the thematic analysis. For example, "quality of care" appears to be located between the themes of *change in therapeutic relationship* and *ethical/moral stance*; similarly, the concept of "therapeutic alliance" maybe located between *the themes of change in therapeutic relationship* and *change in self.*

Common Concerns and Conflicting Strategies

A presentation of the depth and variety of individual participant experiences in the preceding chapter was meant to emphasize differences

among participants. As noted, the thematic structure itself is meant to serve as a common ground and to articulate similar forms of experience among participants. In fact, it is this common ground that allowed the unique pattern of concerns discussed by each participant toward diverse forms of managed care to emerge so clearly.

It is useful to consider whether any given participant adopts a consistent stance toward managed care and whether there are common aspects to the concerns themselves. In other words, it is important to ask whether there are some organizing dimensions that occur among the various situations/transactions. The answer seems to be that there do appear to be some, and the concepts of disposition, position, strategy, and field offered by the sociologist Bourdieu (1992) may serve an organizing function in this regard.

I am, however, cautious about proceeding too far along these lines at present. Given the limited number of participants, it would not be possible to justify empirical generalizations about how various groups of psychotherapists might experience or respond to managed care. Empirical generalizations of this sort would, first of all, require adequately constituted groups of psychotherapists and groups of managed care companies; such data are not available. At present, there is also no empirically tested matrix of social positions that could serve to situate individual psychotherapist experiences in a meaningful space of social practices.

It is possible, however, to describe various sets of common concerns and then to describe some relationships between particular managed care

organizations and their review practices, combined with psychotherapist response to such practices. The more prudent course, therefore, is to remain within the context of individual experience and to discuss how several participants appeared to adopt a consistent set of actions (or strategies) in regard to managed care.

Strategy, in this context, means that set of dispositions and actions participants adopted to promote and/or retain their economic, social or cultural capital. For example, Participant 1 felt that it was difficult to make a living with a full-time private practice because of the predominance of PPOs in her/his community. This participant was unable to join these PPOs even though s/he desired to do so. This participant criticized managed care organizations and his/her own professional organization on normative grounds. The criteria for membership in the PPO was seen as unjust by this participant and s/he advocated action by the professional organization to assert her/his economic interests.

Reconstructing a Sequence of General Transactions

The following discussion examines common concerns among the situations/transactions described by all ten psychotherapists and attempts to reconstruct a temporal sequence of decisions and actions in response to managed care common to some participants. Perhaps the most general approach to the managed care of psychotherapy is that a managed care reviewer requests information about a patient and the psychotherapist then reviews this request with the patient. At some point in time, the reviewer decides that the patient's benefits are exhausted and the psychotherapist

must make a decision on how to continue with his/her patient. Such a decision raises the question of setting fees or renegotiating in order to continue treatment with the patient. Thus, the following subsections present the reconstruction of participants lived-experience as consisting of three steps, with the first involving transactions with a managed care reviewer, the second as involving transactions with patients about managed care reviews, and the third consisting of issues related to setting fees with patients.

1. Transactions with Managed Care Reviewers

Several participants noted that filling out review forms helped to clarify their own clinical reasoning about a case. One participant took this a step further and stated that formulating a treatment plan near the beginning of treatment was beneficial, and that this was compatible with managed care's focus on short-term treatment. Such participant transactions with managed care reviewers were described as cooperative and to result in an adequate extension of third-party reimbursement and maintenance of the treatment relationship. Some participants described how such cooperative interactions with the specific limitations in the number of treatment sessions (or limits that were known ahead of time) led to a particular set of strategies concerning treatment planning and therapeutic technique. Participant 3, for example, described using homework assignments and other cognitive-behavioral techniques that were incorporated into an overall psychodynamic therapeutic program. This was done in conjunction with varying the length of time between sessions. In other words, this therapist chose a strategy of modifying certain features of the therapeutic relationship in response to the

limits of managed care and, on this basis, was able to continue to see the patient.

Another concern shared by several participants was whether the reviewer was a professional peer or someone with less extensive education, training, and/or clinical experience. Some participants only considered a reviewer to be a peer if he or she were from the same discipline with roughly the same level of experience; other participants considered peers to be any reviewer with the roughly the same level of clinical experience. For several participants, a greater degree of congruity with the reviewer's level of training and clinical orientation was experienced as resulting in a more satisfactory review process. This experienced congruity between therapist and reviewer also appeared to result in less of a need to make readjustments in therapeutic relationships or to re-negotiate fees and monetary relationships with clients.

Another crucial feature of the review process which affected the degree of strategic readjustment was whether the reviewer appeared to be working from a formal protocol or from a standardized list of review criteria. The specific managed care review criteria were proprietary and not directly available to participants in any explicit form. When managed care reviewers used standardized review criteria in this manner, it was described as creating experiences of conflict and mistrust.

As noted, virtually any form of managed care review required the psychotherapist to present the patient's case in a form acceptable to the reviewer. When standardized review protocols were used, some participants

chose to respond by presenting the patient's case in a selective manner, emphasizing specific psychopathology. This presentation could have subtle effects on the therapeutic relationship; for example, Participant 10 explored in detail some of the counter-transference issues that this type of review process engendered. S/he chose to respond to these effects by making special efforts to monitor potential counter-transference issues.

Some participants experienced the managed care review process as disruptive to the their clinical practice and, in some cases, damaging to patient welfare. These experiences were responded to in several ways. Some participants spoke about "battling" with managed care reviewers. They described enlisting the support of the patient's family members, obtaining consultations with other mental health professionals, and pursuing legal action to challenge the decisions of managed care reviewers. As a result of these experiences, some participants refused to work with specific third-party insurers or managed care review companies, including various permutations of HMOs and PPOs. One psychotherapist, Participant 4, had already decided to refuse further involvement with any managed care company and several other psychologists were considering such a response. Those participants who were considering this more extreme response discussed the fact that such a decision would have profound consequences on their own economic well-being and life circumstances.

The results of the actual or anticipated transactions with managed care reviewers led some participants to involve patients in the review process and to readjust their monetary relationships with them. These concerns and

strategies are addressed in the following two sub-sections.

2. Transactions with Patients Involving Managed Care Reviews

The most general area of concern involved the release of information to managed care reviewers and the handling of legal and ethical obligations of informed consent and confidentiality. Some participants were surprised to find that they were more concerned about these issues than were their patients. Some participants, however, reported that specific patients terminated treatment when they learned that they would have to release information to outside reviewers. Some participants stated that they attempted to discuss these issues in as neutral a manner as possible whereas other participants made a point of telling their patients that the insurance company was not their ally and that they might find themselves in conflict with their insurer over benefits.

Participant 2 reported that patients would request misinformation be provided to the third-party reimburser in order to save money and to avoid certain review processes or other inconveniences for the patient. This participant reported having to confront his/her patients about these issues and to relate such requests to the therapeutic process. Although some participants reported that discussions about insurance benefits and managed care reviews disrupted the therapeutic relationship, they did not, for the most part, avoid these issues. When patients initiated such conversations, participants reported discussing the practical features of processing review forms as well as its unique psychological meaning for a particular patient.

Nevertheless, some therapists reported that transference reactions to managed care review processes were complicated and less therapeutically productive than transference issues directly involving the therapist-patient dyad.

Several participants did report that showing the patient material that they were sending to the managed care reviewer had a positive impact on the therapeutic relationship. Participant 3 chose to discuss a specific diagnosis with the patient and to request the patient's informed consent to a specific diagnosis. Only one therapist stated that s/he chose specifically to avoid any detailed discussion of the information to be disclosed to a managed care reviewer.

3. Setting Fees with Patients

Participant 6 chose to "reckon" with a patient's finances right at the start of treatment. S/he would begin treatment only with patients who could afford to pay a negotiated fee regardless of the presence of any third-party reimbursement. This was done at the beginning to ensure that any managed care reviews would not lead to a premature termination or to other disruptions in the treatment process. Participant 9 chose to negotiate reduced fees with patients who had some form of managed care fee-for-service, third-party reimbursement. This participant would not set reduced fees or provide free care for persons whose insurance benefits were tied those HMOs or PPOs with which s/he was not affiliated. This participant explained that these organizations were trying "to put me out of business" and to provide reduced fees to patients was understood as subsidizing the

operations of managed care companies. Participants 6 and 9 had developed very clear and explicit strategies about how to respond to the issue of reduced fees.

A wide range of re-negotiations in settings fees was reported once a managed care reviewer limited or curtailed third-party reimbursement. In general, participants reported that they were willing to consider such arrangements with patients in order to continue treatment. Most participants had given the issue some thought and had developed a strategy of how to deal with this issue once it arose in a particular patient's care.

Strategies and Professional Ethos

I have reconstructed a temporal sequence of managed care review processes and consequent therapist-patient transactions to consider the role personal values and professional ethos plays in psychotherapist strategies toward managed care. This pattern of values serves to ground their decision-making and is exemplified in the paradigmatic case analysis presented in Chapter III. Many of the situations/transactions articulated by Participant 7 involved an explicit recognition of the role that values played in her/his experience of managed care.

Participants also described relationships among values, professional ethos, and strategies in terms of the following three issues: (1) sharing accountability for patients' welfare, (2) concerns over the distribution of resources for mental health services and, at the most fundamental level, (3) issues of whether long-term psychotherapy is valued by managed care.

1. Sharing Accountability

Participant 2 described issues related to the ways in which psychotherapists and managed care reviewers struggle over the degree of practical accountability for patients in outpatient psychotherapy who present varying levels of risk in being a danger to themselves or others. Such practical accountability involves the power and responsibility to provide various levels of care from outpatient, to residential, to inpatient treatment. Participant 2's description of accountability also overlaps with legal liability. This participant felt that mental health professionals are responsible for taking collective action to promote a system where psychotherapists and managed care companies would equitably share both the power and the responsibility for patient's care. Participant 7 notes that if psychotherapists are willing to accept third-party payments, they are also accountable and responsible for accepting the scrutiny of third-party reimbursers and managed care reviewers.

A different sense of accountability was present in several participant statements that called on the mental health professions to take action in demonstrating the cost-effectiveness of long-term psychotherapy. Several participants stated that mental health professionals are responsible for educating managed care reviewers and the broader public about the value of long-term psychotherapy.

2. Distribution of Resources for Mental Health Services

A number of participants felt legitimate needs and interests are

served by managed care. Several participants stated that mental health care costs, like other health care costs, need to be contained. A focal concern with issues related to the just distribution of social resources was evident in many discussions. Several participants directly stated that they could appreciate the need to monitor the utilization of services and the review of psychotherapy for this reason. Several participants, however, cast doubt on whether the efficient use of resources was the true motive of managed care companies. They felt, instead, that managed care companies operated in practice to restrict treatment and were interested only in reducing costs.

3. Valuing Long-term Psychotherapy

Several participants realized that managed care is needed to help contain health care costs and were not opposed to managed care in principle. Many of these same participants, however, stated that managed care reviewers do not simply understand or value long-term psychotherapy. In addition, some participants expressed a basic value for long-term work because of the nature of the personal change that they feel is necessary and possible in long-term psychotherapy. Several participants added that their own personal psychotherapy played an important role in the development of this set of values.

Reconstructing Strategies in Response to Specific Forms of Managed Care

Most participants spoke about managed care in general terms; some also spoke about specific organizations or specific review processes. Two of

these examples are briefly presented to describe the ways in which participants experienced the same managed care organization in different ways.

1. Treatment of a Patient within an HMO / IPA (20 session limit)

Participant 1 and Participant 3 have had encounters with the same HMO. This HMO contracts with specific providers, including clinics and independent practitioners, to provide psychotherapy services. Subscribers to the HMO gain access to psychotherapy only through referral from a primary care physician. This plan covers 20 sessions of psychotherapy per year with a graduated co-payment.

Participant 1 encountered patients covered by this HMO through her/his work in an outpatient clinic at a hospital. S/he felt that this form of managed care involved considerable disruption in the treatment process. S/he anticipated that patients would drop out of treatment when co-payments would come into effect. This participant reported that a patient had terminated treatment because the HMO required information about the psychotherapy be disclosed to reviewer. This participant also felt that a limit of 20 sessions would mean that a problem oriented approach rather than a psychodynamic approach would be required. S/he described how this did not meet a specific patient's needs and how it resulted in a sense of straddling two different clinical models, thereby creating confusion about planning a course of treatment.

Participant 3 participated in the same HMO through her/his work in a private practice office setting. S/he felt that graduated co-payments and the 20 session limit were good features of this HMO. This participant felt that this arrangement gives patients time to adjust to the process of psychotherapy. Patients are then better able to decide to continue into long-term treatment or to undertake a time-limited approach. Participant 3 altered treatment techniques to extend the 20 session benefit through intermittent therapy, massed sessions several times per year, homework assignments, and/or shorter sessions. This participant felt that managed care, at times, did promote useful innovation.

2. Working within a Local PPO with Review by a National Managed Care Company

The second managed care company to be considered provides utilization review services to third-party payers and apparently shares no indemnity risk. It also provides managed care services nation-wide and operates through case management reviewers. These reviewers may recommend modifications in the array of services, overall length of psychotherapy, and the frequency of sessions. Participants 4 and 5 had some involvement with this specific company.

Participant 4 reported several cases in which case managers had a disruptive effect on the treatment relationship. Case managers directly contacted patients without the therapist's knowledge. Participant 4 felt that such actions resulted in premature terminations and negative consequences in the lives of some patients. As a result of these interventions by case

managers, this participant chose to resign from this PPO, and refused any further relationship with managed care companies.

Participant 5 also reported a number of negative experiences with the same managed care company. This participant claimed that case management reviews resulted in 14 out of 15 cases being prematurely terminated and that patients were worse off as result. This participant remained engaged with this PPO and continued with some of these patients after their insurance benefits were exhausted. This meant providing reduced fees or free care for some of these patients.

Reconsidering Professional Autonomy and Ethics

Freddi (1989), speaking about the definitions of professional autonomy in the comparative study of medical professions in different national contexts, states:

> However, as soon as we analyze the operational criteria whereby the medical profession can be taken to be autonomous -- as soon as we single out the functional components of autonomy -- we face heuristic ambiguities and contradictions. The main reason is that both the academic and the political debates about medical autonomy are, to varying degrees, still side-tracked by an interpretation which, while empirically grounded at a time when medicine was a "liberal" profession, is no longer supported by fact. To a remarkable extent, what used to be a sound description of the real world of medical practice now resembles ideology. I submit that the structures and behavioral patterns which embodied the notion of medical autonomy until roughly four decades ago have undergone an evolutionary transformation that has changed them almost beyond recognition. (Freddi, 1989, pp. 4-5)

This description may provide an accurate picture of the field of psychotherapy as well. Two of the salient themes characterizing

psychodynamic psychotherapists experience of managed care are *autonomy* and *ethical / moral stance*. The diversity of ways in which these themes are experienced suggests that the corollary concepts of professional autonomy and professional ethics, as used with respect to managed care in the formal discourse of public policy, the mental health professions and the social sciences, must be reconsidered.

Descriptions of the lived experience of present research participants suggest that professional autonomy may not be a coherently and consistently organized concept for them. The concepts of professional autonomy and professional ethics may disguise a variety of conflicts in the individual and in the collective strategies psychotherapists in private practice adopt toward managed care.

In Chapter I a model situating the social space in which the struggles for clinical autonomy occur was presented (Beckman, 1990). In this model, professional authority is placed in a "borderline region" between the expert authority exercised by individuals and the authority exercised within bureaucratic institutions. The interview results and the discussion of concerns and strategies common to participants in the preceding section suggest that individual therapist's freedom to exercise his or her professional authority is rapidly undergoing significant modification. The present participant discussions of the various practices constituting managed care reviews and their strategies toward specific institutional forms of managed care further suggest that bureaucratic and professional authority have become less distinct both in theory and in practice.

For example, an important feature of the psychotherapist's life-world of professional practice is the degree to which the therapists felt that he or she was communicating with a managed care reviewer viewed as a professional peer. If therapists experienced being reviewed by a professional peer, especially one who having a similar theoretical-practical orientation to diagnosis and treatment planning, the review process was experienced as less intrusive. In these circumstances, the review process was described as a matter of negotiation between equals and a less sharply defined boundary was experienced between therapist and reviewer. This experiential boundary defines one feature of the life-world of present participants. It may be the case that the when managed care companies conduct business through professional peer reviewers, managed care may be experienced as less bureaucratic and alien by psychotherapists in independent practice. On the other hand, managed care peer review processes might have the effect of more subtly undermining the independence of professional authority by bureaucratic authority.

Clearly, peer review alone is no guarantee that congruent values between reviewers and practitioners will predominate, or that the review process will be sensitive to the needs of a patient as articulated by independent practitioners. For example, Participant 9 described experiences with a national PPO in which s/he was reviewed by a professional peer. In this participant's experience, however, extensions of payments for more than 10 psychotherapy sessions were granted only in those cases where the patient posed a significant risk of harming him/herself or someone else. Perhaps the surest way for managed care companies to effectively "colonize" (to use

Habermas' ((1987)) phrase) the life-world of psychotherapists in independent practice is to utilize professional peer reviewers who conduct their reviews with inflexible protocols.

Such questioning extends to a reconsideration of the relationship between formal professional ethical guidelines and policy toward managed care, and the particular professional ethos and moral values of individual practitioners. One example may be selected as a point of contrast with the experiences and concerns voiced by present research participants. Writing in a special issue of Professional Psychology: Research and Practice, concerning the issue of managed care, Newman and Bricklin (1991) carefully review the legislative and common law parameters of managed care. They argue that there are inadequate legal controls to prevent adverse impacts of various cost containment strategies upon the quality of mental health services. They also express concern over the fact that providers may be stuck with an unacceptable degree of liability for patient care under a managed care system. A major concern here is that the financial incentives used by HMOs and IPAs, to have providers limit the extent and duration of their services, could result in poorer patient care. Although Newman and Bricklin (1991) argue that the profession of psychology should act to ensure quality of care through its own self-regulation, they side-step any discussion of conflicts internal to the profession over the definition of quality of care. They do describe some of the initiatives proposed by subgroups within APA to assert the needs of women and minorities with respect to specific forms of managed care such as HMOs.

Newman and Bricklin (1991) also acknowledge that the unique problems created by managed care are not dealt with directly by ethical and professional practice guidelines. They review some of the American Psychological Associations policy statements on managed care. It appears that much of the policy on managed care of this professional organization is aimed at ensuring regulation of private managed care companies by the government. While these initiatives will ensure more uniformity and procedural fairness, they do not address the basic value conflicts raised by the present participants' experiences nor do they specify dimensions relevant to defining quality of care.

Formal professional codes of ethics and practice guidelines together with professional policy statements on managed care do not appear to offer specific guidance or aid for practitioners efforts to cope with the diversity of managed care practices. Perhaps formally codified statements and ethical principles are never intended to provide answers to the demands and dilemmas of specific situations. Phenomenological methods, however, are well suited to disclosing the lived meaning of specific situations. The results of the present study suggest that formal professional ethical principles are one part of broader ethical and value orientations that the therapist draws on when he or she must adjust therapeutic work with patients to the new realities of managed care. The results of the present study suggest that professional and public policy attempts to grapple with definitions of quality of care fundamentally involve a complex relationship between beliefs about the nature of the psychotherapeutic process combined with ethical and moral concerns. It is hoped that the methods developed in the present study will

serve as a starting point for bringing questions about professional autonomy, interests and values into the forefront of public policy debates on the future shape of the mental health care system.

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APPENDICES

APPENDIX A

SUBJECT INFORMATION AND CONSENT FORMS

Ralph Warren Jr.
Project Director
(Home) (617) 776-0189 (Work) (617) 876-0426
(Home address)
38 Russell Street
Cambridge, MA 02140

Human Services Research Institute
2336 Massachusetts Avenue
Cambridge, MA 02140

The following information describes the nature of your involvement as a research subject, including rights and responsibilities, in the project entitled: Psychodynamic psychotherapists' experience of managed care: A critical hermeneutic of practical reasoning and public policy. This research will involve audio-taped interviews with psychotherapists who have experienced the impact of managed care on their practice of long-term psychodynamic psychotherapy. Qualitative methods will be used to analyze experiential themes and clinical reasoning in these interviews. The purpose of this research is to describe psychotherapists' experience with and concerns about managed care. This research should contribute to the development of professional standards regarding appropriate access to and availability of long-term psychotherapy services.

As a research subject your involvement will require a one to two hour time commitment. The interview will be conducted by the project director (identified above) in one face-to-face session lasting 45 minutes to 1 hour. After the interview is transcribed, you will be sent a copy of the interview transcript for correction and comment, if necessary, prior to any analysis of the interview. The following two questions, along with follow-up clarifying questions or comments, be used to guide the interview:

Question #1. Please think of some times when you have been aware of the impact of managed care (or utilization management) on your practice of long-term psychodynamic psychotherapy. Please tell me about them;

Question #2. Could you tell me about a case that would be likely to need and benefit from long-term psychodynamic psychotherapy but would not be eligible for this treatment according to the analogue managed care criteria that you have been given? Please discuss the relevant diagnostic and functional criteria and psychodynamic processes without revealing information that could identify individuals.

The analogue managed care criteria are separately enclosed. These analogue criteria are derived from the Massachusetts Department of Mental Health regulations which define priority clients of the department. These criteria are identified as "analogue" in this project because they have no economic, legal or administrative bearing on the actual professional-client relationships between yourself and your private practice clients. All questions in this interview can be usefully discussed without revealing any identifying information about yourself, any of your clients or any other parties. Also, to eliminate any risk to you, you should not discuss any specific actions by any party that could be construed to be a violation of contractual agreements with third-party entities.

The audio-taped interview will be transcribed by the project director and one assistant who will be directly supervised by the project director. The project director will review all audio-tapes prior to transcription to ensure that no personal identifying information is contained on the tapes. Confidentiality will be maintained by coding the tapes and transcripts on one master list. The tapes and master list will be kept in a locked file in a building with security. Only the project director will have access to this locked file. Parts of transcripts from several different research subjects will be discussed in the Phenomenological Research Lab at the University of Tennessee, Knoxville among faculty and graduate students working with these methods. It will be impossible to attribute any of these transcript segments to a research subject.

The foreseeable risks to you as a subject should be minimal. The subjects in this study should benefit by becoming better aware of the demands of managed care reviews and their clients may indirectly benefit as a result. This research should also contribute to the development of professional norms and public policy formulation concerning appropriate access to and availability of long-term psychotherapy. The project director will retain a copy of this form for three years following the completion of this research and return a copy of the signed informed consent to each research participant.

I have understood the conditions of participating this research project as stated above and agree to participate as a research subject. I also understand that I am free to withdraw at any time without questions. Any interview data that I have provided, including audio-tapes and transcripts, would then be immediately destroyed by the project director. If I have any questions at this time, or during or after my participation in this research I can contact the project director at the addresses above.

_____
Name

_____ _____
Signature Date

Ralph Warren Jr.
Project Director
(Home) (617) 776-0189
(Home address)
38 Russell Street
Cambridge, MA 02140

(Work) (617) 876-0426
Human Services Research Institute
2336 Massachusetts Avenue
Cambridge, MA 02140

The following information describes a follow-up request for additional use of the transcript of the research interview that I conducted with you. This interview was done as part of my dissertation research at the University of Tennessee Knoxville under the project entitled: Psychodynamic psychotherapists' experience of managed care: A critical hermeneutic of practical reasoning and public policy. As noted in the original informed consent form, your audio-taped interview was transcribed and you have been sent a copy for any correction and comment. Any potential identifying information has been removed from that transcript. I am now requesting that your full corrected transcript be included as an appendix in my dissertation. I will only be including one of the ten transcripts in that appendix. Your decision to allow inclusion of your transcript is completely voluntary on your part and you may change your decision at any time. Since there is no identifying information in your transcript there should be no additional risks entailed in this present request. Your decision to allow or to not allow your transcript to be included in an appendix does not affect any other conditions of your participation in this research.

I have understood the request for my continued participation in this research project as stated above and the request to include my interview transcript in an appendix. I have reviewed my transcript and agree to have it included in an appendix. I also understand that I am free to rescind this decision or to withdraw at any time without questions. Any interview data that I have provided, including audio-tapes and transcripts, would then be immediately destroyed by the project director. If I have any questions at this time, or during or after my participation in this research I can contact the project director at the addresses above.

_____
Name

_____ _____
Signature Date

APPENDIX B

SUMMARIZING SITUATIONS/TRANSACTIONS FOR THE PARADIGMATIC CASE ANALYSIS

This summary entailed some minor modifications of the original text (see Appendix D for a verbatim transcript). Some redundant statements or phrases were left out. Some sentences were condensed and, at times, some phrases were turned into declarative statements without altering the meaning of the text. However, the majority of the summarized text remains in its exact original form and retains the first person voice. The summary shows which spans of text were organized under each situation/transaction. For some situations/transactions two or more specific descriptions may be combined with general comments. In some cases, general comments have been placed with a description of a specific situation even though these two spans of text were not contiguous in the verbatim transcript.

Situation/transaction #1 - Responding To Communications From Managed Care Reviewers

I do remember one time getting a form, a review form for one of my patients, an adolescent. I had recently filled out a lengthy form for him. I have seen him actually for probably two and a half years before any kind of managed care became involved and that is typical for my caseload. I had the first form, a lengthy form, filled out, had the parents sign a release and mailed it back. Two to three weeks later I got another form from them. There was another very thick form to fill out and my reaction to it was anger. I felt intruded

upon.

General Comments Relating to Situation/transaction #1

My general reaction when I get these communications is to feel anger. I feel that it is an intrusion and I sort of get on a roll thinking that managed care reviewers don't know what they are talking about and their motivations are all screwed up. They are after money and they don't have the welfare of the client in mind. I can really sort of get off on that. I don't even really read what is in front of me, and this example will tell you that.

Description of Situation/transaction #1 (continued)

I saw this new form, I went to the office manager and said I am just going to tell the reviewers look at the old one, look at the one you just got three weeks ago because I was angry and ranting and raving. The new form had questions about the resistance and the transference and wanted me to justify in detail why this case should continue. I went back to my office, looked at the letter again and I realized that the cover sheet to the new review form said that I had 24 sessions approved and that at then end of that 24 sessions if I felt that therapy needed to continue then I would fill out this new form.

General Comments Relating to Situation/transaction #1.1

I am telling you this story to tell you that when I get communications from managed care I get reactive. I do not respond in very productive way initially. I feel intruded upon. I feel rage actually is what I feel, and it takes me time to modulate and get more productive.

Description of Situation/transaction #1.2: Responding to communications from managed care

I got a form after I had sent in the initial review I got back a letter approving a certain number of sessions and the letter said that 112 sessions were approved and I thought, see these people don't know what they are doing, this is a typo, 112! They would never approve a 112 sessions and I was getting ready to take it to the office manager and say "call these people and find out what do they mean, do they mean 12, 112 what do they mean." They are so careless and then, I looked, the same thing happened I went back to the office and looked at it more carefully and realized that they were saying 112 sessions from the beginning of the therapy, which was two to three years ago. So actually that number was about right because there had been about a 100 sessions up until now and they were essentially approving 12 more sessions which is what I had expected.

General comments relating to Situation/transaction #1.2

Again, this second example speaks to my reactivity to this process and I am not proud of that but it is what I intend to do. When I begin to realize that what I have conducted completely autonomously up to now, or quite autonomously, is not as autonomous as it used to be. And I don't feel generous toward it and my initial reaction I feel resentful and then what I try to move toward is a more balanced view of it, when I stop and think about it I am aware that the money that is available for clinical work or long term dynamic psychotherapy is limited and that there has to be some means for distributing the money that is available based on clinical criteria. So I do get

more reasoned about it and try to respond in a balanced and productive way and so I do then.

Situation/transaction #2 - Completing Managed Care Review Forms

Another time when I become aware of managed care is when I am filling out this forms and by that time I am more modulated I am not in a state of anger, I don't feel that resentful, sometimes I do. The resentment is really modulated by that point and I feel a need to modulate because I am not as effective in advocating for my patients if I am in a state of anger. So I modulate. I fill out the forms and the fact is I learn from it, the fact is I do find it useful clinically to organize my thoughts about a given case. I - the way these forms are written they are not conducive to the kind of organization of my thinking that I would choose to do but they are not useless. As you know I would tend to be more behavioral the way I would think about the person and the way I would think about the therapy goals and the progress toward the goals when I am filling out the managed care review forms than I would ordinarily do, but it is a useful thing to do and I see reasons for it. I do feel that there are benefits for me and ultimately for my patients for me to be as deliberate as it has to be.

General Comments Relating to Situation/transaction #2

Another reason that I find it beneficial to write these reviews is that it makes me more accountable to my patient about how I think about what they are doing in therapy, about what we are doing in therapy, because I write very carefully so as to be truthful but not so revealing of detailed information that

it would be a betrayal of confidentiality and that seems useful to me. My sense has been that the patients have been, ah, I was going to say grateful but that's too strong a word, that they have a positive feeling about the fact that I have put that much thought into what we are doing together because aside from our day to day or session to session contact with one another that don't have evidence of that, so for them to see it in writing it tells them something about how much they are in my mind, that they matter to me, enough that I would take the time to do something like this. So in that sense there has been something of a positive result of these discussions.

Situation/transaction #3 - Processing Release Of Information Forms With Patients

Another time that I become aware of managed care and this is a relatively small one but it is important is when I am getting ready to have a patient sign a release form to send this information to managed care because it once again makes me aware that there is a third party or should I say a fourth party involved in this process. There is another person or agency involved in my relationship with my patient and we have to take that into account. And there are times when I resent the presence of that additional party, there are other times when I see realistically it is necessary that some assessment like this is necessary. And I usually try to get myself quite modulated about that before I talk to my patient about it. Because I would find it very counter-productive to convey my resentment to the patient. I think it is something that I am responsible for managing outside, outside of that. I am responsible for managing it and I don't berate myself for feeling the resentment but for

me to bring it into the therapy is counter-productive so I don't do that. If the patient feels resentment we process that.

General comments relating to Situation/transaction #3

So far processing release of information forms has not occurred very much because my caseload has been intruded upon very little so far by managed care. I am sure that those kinds of conversations will become much more prominent in my caseload once sessions start being curtailed and things like that but that has not occurred. So far, it has been very smooth and very brief. I will explain to the patient that there is a managed care agency involved and essentially monitoring what we are doing for purpose of making financial decisions about distribution of insurance money, that kind of thing. That makes sense to them. I show them what I have written and they read it over and the times that has happened which has only been two or three times when we have had that detailed of a conversation about it. Nobody has had any objection, even not very many questions about what I have written. It has worked out OK.

Situation/transaction #4 - Responding To Managed Care's Impact On Professional Peers

Another very important way that I become aware of managed care is when I hear about regulations that are coming into effect that effect other professionals but that don't yet effect me and that is the case in this community because I am not a provider for a [specific PPO]. Well, [a specific company], they have employed a new managed care agency that effects the

[PPO] providers but not those of us who are not providers. And those were pretty dramatic changes that happened and in the month or two after those changes were announced and the therapists who were [PPO] providers were having to do lots and lots of paperwork and talk with their patients about all this. I was very, very aware, probably more than I ever had been about the existence of managed care, the potential impact, and early in that process I also felt, not because it effected me, because I saw it effected other people. I felt anger and resentment about what I saw to be intrusiveness of the process and also what I perceived to be arbitrariness about approval or disapproval about certain numbers of sessions for given patients. I would be very aware of managed care when I would hear a horror story about a case that had been denied further sessions. I won't know until I experience this more first hand whether those things actually happen and how it will effect me and my patients. But I certainly know that I have thought about it a lot when I started hearing about this stuff. In some ways I feel fortunate that regulations did not apply to me right away because it has given me over a year to think about some long range planning for managing managed care. I guess in addition to that period of a couple of months after those regulations were announced the other thing that has had the biggest impact on me or is a time when I am most aware of managed care is when I am talking with colleagues or friends about what kinds of decisions I want to make, the decisions they are making, and what sort of implications this has for us as psychologists.

Situation/transaction #5 - Personal Responsibility And The Responsibility Of Professionals

My sense about this is that once I move past the initial sense of rage and the intrusion and the sense of superiority over these reviewers who don't know as much as I know clinically and all that stuff. Once I move past that and move into the more modulated thing of recognizing that there is a need to find a way to distribute the money that is available, then I see it as an issue of personal responsibility. I see that managed care challenges both therapists and patients with issues of personal responsibility and I feel like in psychology that we live a certain kind of contradiction or I'll just say that I do. On the one hand, I want to make use of insurance reimbursements and in that way I put my self forward as a medical professional, a quasi-medical professional. I want those benefits, but when I am faced with the kind of scrutiny that the medical profession is faced with in obtaining these benefits, then I balk. Then I say I am not like them, psychotherapy is not like medicine, we are not medical, it's psychotherapy, and I see that as a contradiction. Now it is a necessary contradiction because the fact is that I am like medicine and I am different from Medicine, both, we are both of those things. We are care providers but the nature of the care that we provide is different and it lends itself less easily to these kinds of scrutiny but the sense I have about this is that it maybe that both psychologists and patients are going to have to become more responsible for those aspects that are different from medicine and some of the ways that I see my responsibility are - first of all if I see psychology is different, that is, more long term regular care is needed in order for my work to be effective, then I need to conscientiously

justify that. This means that I need to fill out review forms and talk to reviewers in such a way to facilitate that rather than antagonize them. I haven't antagonized them but I certainly have the urges to do it. It is my responsibility to do this conscientiously for the benefit of the patient, not to mention for my own well being. I feel a lot better about myself when I am being more modulated than I do when I am doing that other thing. It is a part of my responsibility to conscientiously fill out review forms and talk to reviewers to get the maximum number of sessions for my patient. I think on the larger level this faces me with the responsibility deciding whether or not to stay involved with third party payers and that is a big responsibility, a big decision. If I should decide not to stay involved with third party payers, then that would face me with a whole other set of decisions and responsibilities. If I were to decide not to be involved I would have to become more responsible for the financial aspect of my relationship with my patients and the way I conduct my practice right now that part of my relationship with my patients is unintegrated, not completely but to some degree it is unintegrated. Other people take care of it, insurance companies pay the money, my office manager takes care of the billing, and I don't have to think about it very much, sometimes I do, but I am not sure that is a good idea.

General Comments Relating to Situation/transaction #5

I think ultimately if I do feel that the kind of control that a third party can have is counterproductive to my work then the most responsible thing for me to do would be to end the relationship with the third party and have the relationship only directly with the patient. I think ultimately that's what

would be most responsible. If I feel that I can manage things without feeling too intruded upon or controlled without the clinical work being compromised too much and maintain the relationship with the third party then that is what I will do. It is too soon for me to tell.

Situation/transaction #6 - Integrating Monetary Issues In The Therapeutic Process

In most of the cases they will pay their copayment but usually they will give that to the office manager when they come in. They usually pay their copayment each time they come in but they don't give it to me and then insurance monies come in. Now there are cases where the person pays that money to me, they will bring me the check for the copayment which is fine and there are also a handful of cases I have where they do give me a check for the full session every time they come and then I reimburse them when I get insurance monies. Frankly, I think that is a better arrangement and it is one reason that I feel not despairing about the future of what I am going to be doing with managed care or without managed care which I have not decided yet. My sense is that for me to be more involved with this process would be better. For me to delegate this to insurance companies and office managers is not a great idea. I see it as, to use a clinical term which I am not fond of, as splitting off something that is important - that really should be more integrated in the relationship. Now that would mean if that were the case and I didn't have insurance companies paying me and my office manager taking care of this, I would have to spend more time doing this kind of thing and that a is a part of the responsibility I would have to bear. I also would

have to make decisions about how - about whether to adjust my fee for some people and I haven't made those decisions up to this point. I have a standard fee for just about everybody I see, I would need to begin to look at what some people can afford, am I willing to make adjustments for that, am I not willing to make adjustments for it. If I am not willing to, that is going to change the nature of my caseloads. How do I feel about doing that? Do I want to serve a segment of the population that can afford to pay out of pocket and not serve people who can't. I don't know yet. But I have to make those decisions and so far I live in a system where I have the luxury of not making those decisions and I would say I am not assuming that aspect of responsibility for my work.

Situation/transaction #7 - Anticipating Lower Fees And Income

So another thing I am aware of is if indeed I would decide not to make use of managed care, not to make use of insurance I mean, I would probably make less money than I make now and that has all kinds of implications. How would I pay my bills? I would have to lower overhead, I would have to lower overhead significantly and if I did that I would not have the kind of office support I have and what would that mean? I thought about all those things. I am willing, I think I would be willing to lower overhead but it would mean that I would have to take on responsibility for certain things that I don't have now. I think adjusting to managed care is very likely to lower my average fee. I don't know that for sure, but I think the likelihood is very high and in fact one reason I live [in a specific set of circumstances] is I know that there is a likelihood that in five years I will be making less money than I make now

because of changes in reimbursement, managed care and possibly a decision of my own to get out of it. [Describes choices and impacts of living situation.] It is related, big life choices I am making right now are related to my awareness of the impact of managed care. So I guess the best way to summarize this whole issue of responsibility is to say that I will become more responsible for the financial aspect of my relationship with my patients and I see that as something positive. Now as far as my patients are concerned they are also going to have to become more responsible, they will have to become responsible for paying their fee if I get out of the relationship with insurance and in fact they are probably going to have to do that even if I stay in because insurance is going to be paying less. I see that as a given.

Situation/transaction #8 - Responsibility To Educate Third Party Reimbursers

I do think that efforts on the part of psychology and other mental health disciplines to educate insurance companies in managed care about the need for long term treatment and the ultimate cost effectiveness of it are very important. I think those efforts are extremely poor and I consider those a part of the responsibility that we need to assume, that I need to assume as a professional because through those efforts it may be possible to increase the amount of money that becomes available through insurance for long term care for these people. That is one reason I feel responsible to fill out these forms conscientiously. I try to educate the reviewers when I do this. I try to find a balance between educating them conveying what I need to about my patient and using only the - using some reasonable amount of time so that I

don't spend too much of my time doing that. But I feel very responsible to do that. I also don't feel very optimistic that there will be much of a change in the trend, however, toward cutting back on mental health monies in insurance. I don't see much likelihood that will change in my professional life time. My sense is that it may be that through efforts to educate third party payers and managed care people, that ultimately they may realize the cost effectiveness of providing long term outpatient care, because I believe that it does prevent inpatient care costs or lower inpatient care costs. But I think it will probably take a generation for that to be realized by third party payers in managed care and it may not be realized but I have to operate on the assumption that it is not going to happen within my professional life time because I don't think it going to. I think the trend now is that the money is going to basically dry up and I have to get ready for that. So it is something I take very seriously but I think the issue of personal responsibility is a good one. I think our profession should be confronted with it. I am not thrilled that we get confronted with it in such an intrusive way, it feels arbitrary, feels controlling but I can't escape from the fact that I should become more responsible for this. I think that part of the reason I feel the rage I feel when I get these things is that I want to avoid that responsibility. I feel rage about being confronted with that responsibility. I think that is what the rage is.

Situation/transaction #9 - Doing Short And Long-term Psychotherapy And A Changing Professional Identity

What I have envisioned is that my caseload will undergo a change. I do primarily long-term work now. I could envision a change where the long-term cases I have are very few, maybe five or six, and those are with people who can basically afford to pay out of pocket because insurance will dry up and then the rest of my caseload will be more short term work that is more governed by managed care and that I would understand that I live in an age of psychology where that kind of transition is going on and where the nature of my work shifts because of the nature of world economy, the nature of economic resources in our country, the nature of the social systems in our country and I could envision making decisions to live within those confines. Even though it would not conform to my original notion of myself as a professional was. I would see myself as a person who is not primarily a long term therapist, but is a person that has that as a favorite thing to do and cherishes those cases where it is possible and also enjoys and learns from those cases that are more short term, much more quick turnover, governed by managed care with a different focus. I would need to learn more about short term care. I feel that I have had a considerable training in short term care but I could learn more about it and would need to. So that is how would change. I would see myself primarily as less a long term therapist. I think by nature I am a person who likes to get to the roots of things. It is more satisfying to me and I think it is probably what drew me to [a particular set of training experiences] because of its focus on clinical work that is what drew me to becoming a long term therapist. I see long term therapy as a way

to get to the roots of things and help people make truly profound changes. That is something I value very much. I find it deeply gratifying and part of the reason that it is so deeply gratifying to me and that I believe in, I truly believe in it, is that it has worked for me. I am a long term patient in therapy and it has transformed my life and I know it works. Certainly that is a part of what underlies the fact that I value it so much. I see it working in my life and I see in working in the lifes of people I know and love also, peers, friends.. So that is a part of it, a personal experience with it and so I orient my life in that way toward a dedication to long term change that is at a very profound level and I have to say I do value that I feel more personally invested in it and I believe it is the way the most true change can happen. So although I feel willing and flexible enough to do shorter term care and I can see that long term care is not a good idea for everybody I don't believe that. That probably for the majority of people shorter term care is really what would be most helpful, what they want, what they can afford. It is not where my heart is as fully. But I feel flexible enough in my professional life to do that for a considerable chunk of my time because I am realizing that I do not think it would take large numbers of long term cases over the next 20 years of my practice for me to feel gratified. I think I could have a handful of long term intensive psychotherapy cases and that would make me feel the kind of gratification I am describing to you without feeling compromised, without feeling I was making too big a personal sacrifice to do the other kind of work.

APPENDIX C

VERBATIM TRANSCRIPT FOR THE PARADIGMATIC CASE ANALYSIS

INTERVIEWER: Please think of times when you have been aware of the impact of managed care or utilization management on your practice of long term psychodynamic psychotherapy. Please tell me about them.

THERAPIST: The one time that I am aware of it is when I get a review form or some other form of communication from managed care. Do you want me to talk about specific times that's happened or talk in a more general sense about what happens when I get a form like that?

INTERVIEWER: Both but I think it helps, at least for you to have some specific instances in mind, and if you feel free in talking about them without giving identifying information that would be helpful.

THERAPIST: OK. For this part there is really very little in terms of specific clinical material that I will be talking about because as I thought about this question I thought more in terms of how I experienced the whole managed care process. I do remember one time getting a form, a review form for one of my patients, an adolescent. I had recently filled out a lengthy form for him. I have seen him actually for probably two and a half years before any kind of managed care thing came into being and that is typical for my caseload. So I had gotten the first form and it was a lengthy thing and I had filled it out and gotten the parents to sign a release and mailed it back and then probably two to three weeks later I got another form from them, or so I thought. I got something in the mail. I opened it up. There was another very thick form to fill out and my reaction to it was anger. I felt intruded upon. My general reaction when I get these communications is to feel anger. I feel that it is an intrusion and I sort of get on a roll thinking that these people don't know what they are talking about and their motivations are all screwed up and they are after money. They don't have the welfare of the client in mind, and I can really sort of get off on that you know. I don't even really read what is in front of me, and this example will tell you that. Because what I did is I got this thing, I saw this new form, I went to the office manager and said "look at this thing!" I just filled out this other one, these are the same questions and they got even more question and I am just going to say "look at the old one! look at the old one! Look at the one you just got three weeks ago!" And cause I was angry. So she was looking at this and said I've never seen one with as detailed questions. They had questions about the resistance and the transference. They wanted me to justify in detail why this case should continue and I'm going and I just filled out another one and ranting and raving and just said "well make a copy of this and I'll just start filling it out." I went back to my office, looked at the letter again and I realized that the cover sheet to this thing said that I had 24 sessions approved and that at then end of that 24 sessions if I felt that therapy needed to continue then I would fill out this form. I am telling you this story to tell you that when I get

communications from managed care I get reactive. I do not respond in very productive way initially. I feel intruded upon. I feel rage actually is what I feel, and it takes me time to modulate and get more productive. That is a fairly typical example. I have another sort of less dramatic example, where I got a form after I had sent in the initial review I got back a letter approving a certain number of sessions and the letter said that 112 sessions were approved and I thought, see these people don't know what they are doing, this is a typo, 112! They would never approve a 112 sessions and I was getting ready to take it to the office manager and say "call these people and find out what do they mean, do they mean 12, 112 what do they mean." They are so careless and then, I looked, the same thing happened I went back to the office and looked at it more carefully and realized that they were saying 112 sessions from the beginning of the therapy, which was two to three years ago. So actually that number was about right because there had been about a 100 sessions up until now and they were essentially approving 12 more sessions which is what I had expected. But again it speaks to my reactivity to this process and I am not proud of that but it is what I intend to do. When I begin to realize that what I have conducted completely autonomously up to now, or quite autonomously, is not as autonomous as it used to be. And I don't feel generous toward it and my initial reaction I feel resentful and then what I try to move toward is a more balanced view of it, when I stop and think about it I am aware that the money that is available for clinical work or long term dynamic psychotherapy is limited and that there has to be some means for distributing the money that is available based on clinical criteria. So I do get more reasoned about it and try to respond in a balanced and productive way and so I do then. Another time when I become aware of managed care is when I am filling out these forms and by that time I am more modulated I am not in a state of anger, I don't feel that resentful, sometimes I do. The resentment is really modulated by that point and I feel a need to modulate because I am not as effective in advocating for my patients if I am in a state of anger. So I modulate. I fill out the forms and the fact is I learn from it, the fact is I do find it useful clinically to organize my thoughts about a given case. I - the way these forms are written they are not conducive to the kind of organization of my thinking that I would choose to do but they are not useless. As you know I would tend to be more behavioral the way I would think about the person and the way I would think about the therapy goals and the progress toward the goals, than I would ordinarily do, but it is a useful thing to do and I see reasons for it.

INTERVIEWER: So there is an initial feeling usually of anger and resentment, being intruded upon. Then when you are actually going through the process of doing the review and this is typically in written form you can see an advantage and a disadvantage.

THERAPIST: Exactly.

INTERVIEWER: Are there different ways that these reviewers request the information that make it more of an advantage of disadvantage for you?

THERAPIST: I am trying to think whether I have had enough variation in terms of requests to know that and actually there has been very little

variation so far in my case load. Most of my requests come from [national managed care company] which is the company that manages care for [a specific employer]. I have had one or two other reviews but they don't stand out. So I don't have a basis for comparison. I think I probably will. I know I will within a year or two.

INTERVIEWER: So before I asked that, you were getting into a positive sense as well.

THERAPIST: Yeah, I do feel that there are benefits for me and ultimately for my patients for me to be as deliberate as it has to be. Another time that I become aware of managed care and this is a relatively small one but it is important is when I am getting ready to have a patient sign a release form to send this information to managed care because it once again makes me aware that there is a third party or should I say a fourth party involved in this process. That there is another person or agency involved in my relationship with my patient and we have to take that into account. And there are times when I resent the presence of that additional party, there are other times when I see realistically it is necessary that some assessment like this is necessary. And I usually try to get myself quite modulated about that before I talk to my patient about it. Because I would find it very counter-productive to convey my resentment to the patient. I think it is something that I am responsible for managing outside, outside of that. I am responsible for managing it and I don't berate myself for feeling the resentment but for me to bring it into the therapy is counter-productive so I don't do that. If the patient feels resentment we process that. So far that hasn't happened very much because my caseload has been intruded upon very little so far by managed care. I am sure that those kinds of conversations will become much more prominent in my caseload once sessions start being curtailed and things like that but that has not occurred.

INTERVIEWER: How does that effect the process between you and the patient when you do have to go through explaining or seeking an agreement with them about the working process?

THERAPIST: So far, it has been very smooth, very brief and very smooth. I will explain to the patient that there is a managed care agency involved and essentially monitoring what we are doing for purpose of making financial decisions about distribution of insurance money, that kind of thing. That makes sense to them. I show them what I have written and they read it over and the times that has happened which has only been two or three times when we have had that detailed of a conversation about it. Nobody has had any objection, even not very many questions about what I have written. It has worked out OK. Another reason that I find it beneficial to write these reviews is that it makes me more accountable to my patient about how I think about what they are doing in therapy, about what we are doing in therapy, because I write very carefully so as to be truthful but not so revealing of detailed information that it would be a betrayal of confidentiality and that seems useful to me. My sense has been that the patients have been, ah, I was going to say grateful but that's too strong a word, that they have a positive feeling about the fact that I have put that much thought into what

we are doing together because aside from our day to day or session to session contact with one another that don't have evidence of that, so for them to see it in writing it tells them something about how much they are in my mind, that they matter to me, enough that I would take the time to do something like this. So in that sense there has been something of a positive result of these discussions. Again this may come to these negative results but so far that really hasn't happened. Does that answer that?

INTERVIEWER: Yeah. Yeah.

THERAPIST: Another very important way that I become aware of managed care is when I hear about regulations that are coming into effect that effect other professionals but that don't yet effect me and that is the case in this community because I am not a provider for a [specific PPO]. Well, [a specific company], they have employed a new managed care agency that effects the [PPO] providers but not those of us who are not providers. And those were pretty dramatic changes that happened and in the month or two after those changes were announced and the therapists who were [PPO] providers were having to do lots and lots of paperwork and talk with their patients about all this. I was very, very aware, probably more than I ever had been about the existence of managed care, the potential impact, and early in that process I also felt, not because it affected me, because I saw it affected other people. I felt anger and resentment about what I saw to be intrusiveness of the process and also what I perceived to be arbitrariness about approval or disapproval about certain numbers of sessions for given patients. I would be very aware of managed care when I would hear a horror story about a case that had been denied further sessions. Somebody who was - I remember a particular colleague who had a patient who was suicidal, who was approved I think for six more sessions and that was all, even though the person was quite actively suicidal and who knows that is a very second hand story and I don't know the details but I do know that stories like that were circulating in the community and that it added to the sense of anger and this kind of intrusion. I won't know until I experience this more first hand whether those things actually happen and how it will effect me and my patients. But I certainly know that I have thought about it a lot when I started hearing about this stuff. In some ways I feel fortunate that regulations did not apply to me right away because it has given me over a year to think about how I want to manage this, to begin to think about some long range planning for managing managed care and I guess in addition to that period of a couple of months after those regulations were announced the other thing that has had the biggest impact on me or is a time when I am most aware of managed care is when I am talking with colleagues or friends about how - what kinds of decisions I want to make, about the decisions they are making - what sort of implications this has for us as psychologists.

INTERVIEWER: Can you share some of that sense with me?

THERAPIST: My sense about this is that once I move past the initial sense of rage and the intrusion and the sense of superiority over these reviewers who don't know as much as I know clinically and all that stuff. Once I move past that and move into the more modulated thing of recognizing that there

is a need to find a way to distribute the money that is available, then I see it as an issue of personal responsibility. I see that managed care challenges both therapists and patients with issues of personal responsibility and I feel like in psychology that we live a certain kind of contradiction or I'll just say that I do. On the one hand, I want to make use of insurance reimbursements and in that way I put my self forward as a medical professional, a quasi-medical professional. I want those benefits, but when I am faced with the kind of scrutiny that the medical profession is faced with in obtaining these benefits, then I balk. Then I say I am not like them, psychotherapy is not like medicine, we are not medical, it's psychotherapy, and I see that as a contradiction. Now it is a necessary contradiction because the fact is that I am like medicine and I am different from medicine, both, we are both of those things. We are care providers but the nature of the care that we provide is different and it lends itself less easily to these kinds of scrutiny but the sense I have about this is that it maybe that both psychologists and patients are going to have to become more responsible for those aspects that are different from medicine and some of the ways that I see my responsibility are - first of all if I see psychology is different, that is, more long term regular care is needed in order for my work to be effective, then I need to conscientiously justify that. Which means that I need to fill out review forms and talk to reviewers in such a way to facilitate that rather than antagonize them, which I haven't done, but I certainly have the urges to do it. The urges I have is to write "f... you" on these forms, "look at the last one, it is the same as it was before", or to be antagonistic to them over the phone. Those are the urges I have, I don't do those things, but those are the urges and it is my responsibility to do this conscientiously for the benefit of the patient. Not to mention for my own well being. I feel a lot better about myself when I am being more modulated than I do when I am doing that other thing. So that is a part of my responsibility, to do it conscientiously, to get the maximum number of sessions for my patient. But I think on the larger level this faces me with the responsibility deciding whether or not to stay involved with third party payers and that is a big responsibility, a big decision. If I should decide not to stay involved with third party payers, then that would face me with a whole other set of decisions and responsibilities. If I were to decide not to be involved I would have to become more responsible for the financial aspect of my relationship with my patients and the way I conduct my practice right now that part of my relationship with my patients is unintegrated, not completely but to some degree it is unintegrated. Other people take care of it, insurance companies pay the money, my office manager takes care of the billing, and I don't have to think about it very much, sometimes I do, but I am not sure that is a good idea.

INTERVIEWER: So typically in your practice, you, at least on a regular basis, you are not receiving a check directly from the patient things like that, that some people may chose to do. So that you keep directly involved in the process, the financial arrangements.

THERAPIST: Right, that is true in some cases. I have some cases, most of my cases don't involve direct contact between me and the patient about their bill.

INTERVIEWER: Ok, I just wanted to clarify that.

THERAPIST: Some do. In most of the cases they will pay their copayment but usually they will give that to the office manager when they come in. They usually pay their copayment each time they come in but they don't give it to me and then insurance monies come in. Now there are cases where the person pays that money to me, they will bring me the check for the copayment which is fine and there are also a handful of cases I have where they do give me a check for the full session every time they come and then I reimburse them when I get insurance monies. Frankly, I think that is a better arrangement and it is one reason that I feel not despairing about the future of what I am going to be doing with managed care or without managed care which I have not decided yet. My sense is that for me to be more involved with this process would be better. For me to delegate this to insurance companies and office managers is not a great idea. I see it as, to use a clinical term which I am not fond of, as splitting off something that is important - that really should be more integrated in the relationship. Now that would mean if that were the case and I didn't have insurance companies paying me and my office manager taking care of this, I would have to spend more time doing this kind of thing and that a is a part of the responsibility I would have to bear. I also would have to make decisions about how - about whether to adjust my fee for some people and I haven't made those decisions up to this point. I have a standard fee for just about everybody I see, I would need to begin to look at what some people can afford, am I willing to make adjustments for that, am I not willing to make adjustments for it. If I am not willing to, that is going to change the nature of my caseloads. How do I feel about doing that? Do I want to serve a segment of the population that can afford to pay out of pocket and not serve people who can't. I don't know yet. But I have to make those decisions and so far I live in a system where I have the luxury of not making those decisions and I would say I am not assuming that aspect of responsibility for my work. So another thing I am aware of is if indeed I would decide not to make use of managed care, not to make use of insurance I mean, I would probably make less money than I make now and that has all kinds of implications. How would I pay my bills? I would have to lower overhead, I would have to lower overhead significantly and if I did that I would not have the kind of office support I have and what would that mean? I thought about all those things. I am willing, I think I would be willing to lower overhead but it would mean that I would have to take on responsibility for certain things that I don't have now.

INTERVIEWER: Do you think, this is kind of a specific, pragmatic question in line with what you are saying, do you think that would effect your average fee per person per hour?

THERAPIST: I think it is very likely. I think it is very likely to lower the average fee. I don't know that for sure, but I think the likelihood is very high and in fact one reason I live [in a specific set of circumstances] is I know that there is a likelihood that in five years I will be making less money than I make now because of changes in reimbursement, managed care and possibly a decision of my own to get out of it. [Describes choices and impacts of living situation.] It is related, big life choices I am making right now are related to

my awareness of the impact of managed care. So I guess the best way to summarize this whole issue of responsibility is to say that I will become more responsible for the financial aspect of my relationship with my patients and I see that as something positive. Now as far as my patients are concerned they are also going to have to become more responsible, they will have to become responsible for paying their fee if I get out of the relationship with insurance and in fact they are probably going to have to do that even if I stay in because insurance is going to be paying less. I see that as a given. I do think that efforts on the part of psychology and other mental health disciplines to educate insurance companies in managed care about the need for long term treatment and the ultimate cost effectiveness of it are very important. I think those efforts are extremely poor and I consider those a part of the responsibility that we need to assume, that I need to assume as a professional. Because through those efforts it may be possible to increase the amount of money that becomes available through insurance for long term care for these people. That is one reason I feel responsible to fill out these forms conscientiously. I try to educate the reviewers when I do this. I try to find a balance between educating them conveying what I need to about my patient and using only the - using some reasonable amount of time so that I don't spend too much of my time doing that. But I feel very responsible to do that. I also don't feel very optimistic that there will be much of a change in the trend, however, toward cutting back on mental health monies in insurance. I don't see much likelihood that will change in my professional life time. My sense is that it may be that through efforts to educate third party payers and managed care people, that ultimately they may realize the cost effectiveness of providing long term outpatient care, because I believe that it does prevent inpatient care costs or lower inpatient care costs. But I think it will probably take a generation for that to be realized by third party payers in managed care and it may not be realized but I have to operate on the assumption that it is not going to happen within my professional life time because I don't think it going to. I think the trend now is that the money is going to basically dry up and I have to get ready for that. So it is something I take very seriously but I think the issue of personal responsibility is a good one. I think our profession should be confronted with it. I am not thrilled that we get confronted with it in such an intrusive way, it feels arbitrary, feels controlling but I can't escape from the fact that I should become more responsible for this. I think that part of the reason I feel the rage I feel when I get these things is that I want to avoid that responsibility. I feel rage about being confronted with that responsibility. I think that is what the rage is.

INTERVIEWER: Ok. But you are also saying that in some ways you imagine a more positive way of responding to that responsibility other than it being done by a third party - something like that. Can you say something about that.

THERAPIST: Yeah, well lets see. Do you mean the ideas I was having about just not being involved with the third party at all.

INTERVIEWER: That is one, maybe others that you had to. That is one way to take on the personal responsibility for that.

THERAPIST: I guess that is the main one I think of these days.

INTERVIEWER: OK.

THERAPIST: Well, I mean if I were to stay within the confines of using a third party, then the way I feel I would need to be more responsible is by doing the forms conscientiously. I don't mean to suggest I don't do them conscientiously, I need to continue to do that. To take them seriously, to resent them less and to see them as a form of responsibility that I need to take. I think ultimately if I do feel that the kind of control that a third party can have is counterproductive to my work then the most responsible thing for me to do would be to end the relationship with the third party and have the relationship only directly with the patient. I think ultimately that's what would be most responsible. If I feel that I can manage things without feeling too intruded upon or controlled without the clinical work being compromised too much and maintain the relationship with the third party then that is what I will do. It is too soon for me to tell. What I have envisioned is that my caseload will undergo a change. I do primarily long-term work now. I could envision a change where the long-term cases I have are very few, maybe five or six, and those are with people who can basically afford to pay out of pocket because insurance will dry up and then the rest of my caseload will be more short term work that is more governed by managed care and that I would understand that I live in an age of psychology where that kind of transition is going on and where the nature of my work shifts because of the nature of world economy, the nature of economic resources in our country, the nature of the social systems in our country and I could envision making decisions to live within those confines. Even though it would not conform to my original notion of myself as a professional was.

INTERVIEWER: How would that change your notion of yourself as a professional?

THERAPIST: I would see myself as a person who is not primarily a long term therapist, but is a person that has that as a favorite thing to do and cherishes those cases where it is possible and also enjoys and learns from those cases that are more short term, much more quick turnover, governed by managed care with a different focus. I would need to learn more about short term care. I feel that I have had a considerable training in short term care but I could learn more about it and would need to. So that is how would change. I would see myself primarily as less a long term therapist.

INTERVIEWER: I get the sense from the last part of your discussion here that there is an important difference between just the whole approach in doing those kinds of therapies and maybe some values that are involved with those two approaches or other aspects of whatever about those two differences are important to you. Could you describe that a little more?

THERAPIST: I think by nature I am a person who likes to get to the roots of things. It is more satisfying to me and I think it is probably what drew me to [a particular set of training experiences] because of its focus on clinical work that is what drew me to becoming a long term therapist. I see long term

therapy as a way to get to the roots of things and help people make truly profound changes. That is something I value very much. I find it deeply gratifying and part of the reason that it is so deeply gratifying to me and that I believe in, I truly believe in it, is that it has worked for me. I am a long term patient in therapy and it has transformed my life and I know it works. Certainly that is a part of what underlies the fact that I value it so much. I see it working in my life and I see in working in the lifes of people I know and love also, peers, friends.. So that is a part of it, a personal experience with it and so I orient my life in that way toward a dedication to long term change that is at a very profound level and I have to say I do value that I feel more personally invested in it and I believe it is the way the most true change can happen. So although I feel willing and flexible enough to do shorter term care and I can see that long term care is not a good idea for everybody I don't believe that. That probably for the majority of people shorter term care is really what would be most helpful, what they want, what they can afford. It is not where my heart is as fully. But I feel flexible enough in my professional life to do that for a considerable chunk of my time because I am realizing that I do not think it would take large numbers of long term cases over the next 20 years of my practice for me to feel gratified. I think I could have a handful of long term intensive psychotherapy cases and that would make me feel the kind of gratification I am describing to you without feeling compromised, without feeling I was making too big a personal sacrifice to do the other kind of work. Does that help?

INTERVIEWER: Yeah, that helps explain that.

THERAPIST: That's about it.

INTERVIEWER: Ok, we'll move on to the second question...

VITA

Ralph Warren Jr. was born in Huntington, New York on December 12, 1955. He received the Bachelor of Arts in Psychology and Philosophy from the State University of New York at Binghamton in 1979. He took Masters level courses in Philosophy at the State University of New York at Binghamton from 1980 through 1982. In August, 1982 he entered The University of Tennessee, Knoxville and in May, 1993 he received a Doctor of Philosophy degree in Psychology.

He has been employed for the past several years in crisis intervention services in a mental health center and in a research and consulting company. He has also been a visiting lecturer at Bentley College and Tufts University.