

Is Three a Crowd? Clients, Clinicians, and Managed Care

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How does therapy change when therapists work under managed care plans? To explore this question, the authors conducted in-depth, semistructured interviews with therapists. The interview texts were analyzed using a structured thematic coding system. A central theme in the interviews was a culture clash between managed care companies and these therapists. Working for managed care organizations demanded several practices that violated the therapists' standard of care and professional ethics. Also, participants reported that managed care personnel misrepresented the nature of psychotherapy to clients, thereby undermining the therapeutic work and the therapist-client relationship. If these therapists' experiences are representative, the growth of managed care has serious implications for the nature of psychotherapy, practitioners' integrity and morale, and the public image of the therapy professions.

Keywords: managed care, therapist-client relationship, professional ethics, therapeutic alliance

Managed mental health care has expanded rapidly over the past 20 years. By the late 1990s, 75% of Americans with health insurance were enrolled in managed care plans (Kiesler, 2000). In a survey of members of the American Psychological Association (APA) Division 42 (Psychologists in Independent Practice) conducted in the mid 1990s, 84% of the respondents said they were members of panels of health maintenance organizations (HMOs) or preferred provider organizations (PPOs) (Murphy, DeBernardo, & Shoemaker, 1998); the percent may be even higher now.

Managed care can be understood in a number of ways: "a way of providing care, a philosophy of care, a way to finance care, and a way to control costs" (Talbot, 2001, p. 279). To contain costs, certain types of treatment are authorized while other kinds of care are excluded from reimbursement; the amounts of treatment are usually limited as well. The umbrella term "managed care" covers several types of plans. The two most common are HMOs and PPOs. HMOs are capitated systems in which health care consumers choose a primary physician whom they must see first in order to be treated (Fabius, 1997). The provider authorizes specialty treatments (such as psychotherapy). Often the provider is offered a financial incentive for limiting such authorizations. In contrast, PPOs permit health care consumers to choose providers from a network of professionals. These providers usually must accept reduced fees in order to participate and often must agree to some

degree of outside review as well (Kent & Herson, 2000). Various plans, of course, differ in their specifics.

Managed care has imposed numerous changes on the practice of psychotherapy. Some changes, such as the regulation of the length, style, or goals of treatment by a third party extrinsic to the therapy relationship and lower fees for therapists, are overt and obvious to all. But there may be other less apparent but crucial shifts as well. This study, which draws on in-depth, semistructured interviews with therapists who had experience with managed care plans, inquires into transformations in therapy process and in therapist-client interactions that managed care might bring.

A number of paper and pencil surveys have gauged psychotherapists' opinions about managed care and its effects on their work activities and job satisfaction. By and large, these surveys have involved mass mailings to therapists, using instruments with closed-ended response formats, such as checklists and Likert scales. In a nationwide survey of 15,918 clinical psychologists, 79% reported that the effect of managed care on their professional work was negative (Phelps, Eisman & Kohout, 1998). Similarly, in a survey of 442 psychologists in independent practice drawn from 9 geographic regions in the United States, most (86%) said that their work had been negatively affected by managed care (Murphy, DeBernardo, & Shoemaker, 1998). Responding to the checklist that Murphy et al. provided, therapists endorsed the following problems (ordered with the most frequent first): limitations on the number of sessions, decreased flexibility and room for clinical judgment, termination of treatment before clients were ready, decreased time for assessment, restrictions on which clients could be served, increased pressure to make referrals for medication, requirements that therapists follow specific treatment protocols, and demands that therapists use treatments outside their primary orientation. Other surveys of therapists have suggested that therapy under managed care is usually abbreviated. For example, Gold and Shapiro (1995) compared a sample of psychologists in Florida who worked under managed care contracts to those who did not. The former reported seeing clients for significantly fewer sessions. In another study, therapists reported that their clients frequently had to discontinue treatment prematurely because of managed care

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limitations (Chambliss, Pinto, & McGuigan, 1997). Similarly, Danzinger and Welfel (2001) found that 46% of mental health counselors reported that when working under managed care contracts, they had terminated or would have to terminate therapy before clients were ready.

Surveys of therapists also have found that many of them have ethical concerns about some aspects of managed care, particularly regarding privacy and confidentiality. In Danzinger and Welfel's (2001) survey, approximately 75% of mental health counselors reported that managed care presented ethical problems. In the survey by Murphy and colleagues, 70% of respondents reported that they experienced more ethical problems associated with managed care than with their general practice. Moreover, 75% of the respondents agreed that "contact with managed care and utilization review compromises patient confidentiality." Fifty-three percent doubted that managed care personnel kept clinical information confidential. Many of the therapists surveyed by Chambliss, Pinto, and McGuigan (1997) believed that managed care procedures compromise clients' confidentiality. A survey of New Jersey psychologists (Rothbaum, Bernstein, Haller, Phelps, & Kohout, 1998) found that psychologists with a higher proportion of managed care caseloads were more likely to report pressures to compromise both quality of care and ethical principles.

A number of commentators have raised concerns that managed care changes not only the contractual terms under which therapy is provided to clients, but also the fundamental activities, practices, and social relations that constitute psychotherapy. Gold and Shapiro (1995, p. 54), for example, worried that managed care may be "subverting [therapists'] previously held convictions about what constitutes effective clinical practice." In the same vein, a recent ethnography of a clinical setting labeled managed care as the "Walmart-ing" of psychotherapy (Donald, 2001). A long-term prospective ethnography of a mental health clinic in the Boston area found that as therapists prepared for managed care, they anticipated that conforming to its policies would place them in fundamental violation of their ethos of good care (Ware, Lachicotte, Kirschner, Cortes, & Good, 2001). Luhrmann's (2000) provocative ethnography of psychiatric residency training documents, a "growing disorder" as the humanistic values embodied in certain forms of psychotherapy give way to the bureaucratic regimentation and corporate culture of managed care organizations. Cushman and Gilford (2000) made the argument that the style of discourse and treatment philosophy of managed care organizations significantly reconfigures both the identity of therapy clients and that of therapists. Clients, they argue, become "compliant recipients of expert knowledge and technique" (p. 987), while the therapist is made into an "impersonal . . . dispenser of a predetermined set of technical maneuvers" (p. 989).

In this study, we investigate more closely if and how the context of managed care might change the "inside" of therapy. We ask if therapists' practices and clients' experiences in therapy sessions are changed by the demands of managed care. Instead of opinion surveys and checklists, we rely on private, one-on-one interviews in order to gather fine-grained portrayals of therapists' firsthand experiences and perceptions. Rather than constrain participants by fixed-format response categories and Likert scales, we designed a semistructured interview composed of open-ended questions. This format enabled participants to formulate their experiences and ideas in their own words. In our analysis, we focus less on

participants' encounters with managed care companies and more on their reflections about the unfolding therapist-client relationship, the roles and expectations of therapists and clients, and the conduct of therapy itself.

Method

Potential participants were nominated by two key informants within the practitioner community. We asked these informants to supply names of practitioners they knew who had current or very recent experience on a managed care panel. This initial pool of nominees yielded 15 participants. (A few of the nominees were ineligible because they had no recent experience with managed care. Two declined to participate because of lack of time.) Three additional participants were nominated by the initial participants. For all nominees, the sole criterion was current or very recent experience with managed care; we did not seek therapists who had negative (or positive) views of managed care. Each nominee was contacted by phone and asked to participate in a study about managed care. A formal letter describing the study followed and written consent was obtained before the interview was conducted.

This recruitment technique yielded a high response rate and a group of articulate and thoughtful participants. It did not, of course, produce a random or representative sample. All told, 18 therapists (6 men and 12 women) were interviewed. Sixteen (6 men and 10 women) were licensed clinical psychologists, 1 was a psychiatrist, and 1 was a clinical social worker. Their length of experience varied widely (range = 2 to 44 years, median = 16 years). Sixteen were White, one was Asian American, and one was African American. Seven of the therapists described their approach as eclectic, four were primarily psychodynamic, three were humanistic/experiential; two were primarily cognitive-behavioral, and two were psychoanalytic. All but three practiced in a large metropolitan area in the mid-Atlantic region. (The remaining three were practicing in Massachusetts, California, and Ohio, respectively, at the time of the interview.) All participants had current or recent experience with managed care, and many were on several managed care panels. Table 1 summarizes participants' backgrounds.

Depending on geographic proximity, participants were interviewed either in person or by telephone. The interviews lasted roughly 1 hour. The

Table 1
Participants' Backgrounds

Gender	Years in practice ^a	Primary orientation
Female	2	Psychodynamic
Male	12	Humanistic/experiential
Male	16	Eclectic
Female	12	Humanistic/experiential
Male	12	Eclectic
Female	20	Eclectic
Female	12	Eclectic
Female	28	Eclectic
Female	4	Psychoanalytic
Male	44	Eclectic
Male	24	Psychoanalytic
Female	15	Cognitive-Behavioral
Female	30	Psychodynamic
Male	35	Humanistic/experiential
Female	14	Cognitive-Behavioral
Female	10	Psychodynamic
Female	23	Psychoanalytic
Female	21	Eclectic

^a Years experience subsequent to the completion of the participant's terminal degree.

interviews involved 1) a standard set of questions eliciting information about the participant's clinical practice, client population, and the history of his or her involvement with managed care companies; 2) open-ended questions about experiences doing therapy under managed care; and 3) open-ended questions about strategies for working with managed care companies.¹ Some sample questions are:

How, if in any way, has managed care changed what you do in your practice?

Do you begin therapy differently with managed care clients than with other clients?

Does managed care affect termination?

Has managed care made any positive changes in the way you do therapy?

The interviews were tape-recorded and transcribed. We analyzed them using the structured data analytic approach developed by Auerbach and Silverstein (2003). This approach is based on the grounded theory analysis developed by Glaser and Strauss (1967), which is widely used by qualitative researchers in many disciplines. The term "grounded theory" refers to the idea of devising theoretical constructs "from the ground up," that is, using empirical data to generate theoretical constructs. This inductive process is, of course, distinct from the hypothetico-deductive method; it is not aimed at hypothesis testing.

Our analytic approach involved a series of systematic steps. These involved locating "repeating" or common ideas in unstructured talk and using the method of constant comparison of these ideas to move from participants' own words to higher-order themes. In the first step of the analysis, we identified all the segments of the interview texts that pertained to each of our research questions, irrespective of where those segments occurred. Retaining the participants' own wordings, we then compared segments to one another to make groupings of similar ideas. The next step involved combining these groups into more general themes. Two of the researchers (JC and JM) were responsible for the data analysis. After a preliminary discussion, they carried out the analytic process independently. Then the two sets of repeating ideas and general themes were brought together. All three authors discussed this body of material until the inconsistencies were resolved. In the description of the results that follows, we focus primarily on the meanings that participants themselves gave to their experiences. However, we also offer some observations and interpretations that emerged from considering the body of interview material as a whole.

Results

The analysis of the transcripts focused on three broad questions: 1) How does working within managed care systems change therapists' approaches to therapy? 2) What differences—good and bad—do therapists see in clients who enter therapy through a managed care plan? and 3) How do therapists respond to demands from managed care companies when they regard those demands as countertherapeutic or as unethical?

I. How Does Managed Care Change Therapists' Approaches to Therapy?

Two overarching themes emerged in answer to this question. The first was that the constraints imposed by managed care required therapists to alter their treatment strategies. In participants' eyes, the required changes often compromised their standard of good care. The participants reported numerous ways in which their

treatment strategies were altered. We list the issues mentioned most frequently, illustrated with excerpts from the interviews.²

A. Therapists feel compelled to focus on superficialities without addressing underlying problems. Most participants in the study (15 out of 18) reported that under managed care, they were sometimes compelled to limit the focus of therapy to superficial problems or surface changes. Working on deeper or more long-standing problems would require longer or more intensive therapy than managed care companies would pay for. This was a source of considerable frustration for participants. Sometimes it raised ethical concerns as well because participants felt obliged to offer treatment they regarded as inadequate and insufficient.

If I know ahead of time that a person's coverage allows for, say, 10 visits or 20 visits, that it is not a negotiable thing. . . . Depending on what their problems are, there might be things I get into and other things I just do not get into whatsoever because there's no time to really get in and really properly work on them. Then, I might. . . focus almost totally on reduction of their symptoms or modifications of their behavior, something of this nature—without what I would consider really working through the stuff that is behind it. Just trying to get them to function better, you know, feel better. (#11)

It seems to me that managed care, calling it "behavioral health," is just that. They want us to normalize the person's behavior and get them back in the workplace, so the employer will be satisfied with the contract. That is all they care about. They do not care if these people go home every night depressed or do not have a social life or are not happy in their marriage. Just so they're functioning. You know, it is kind of like battlefield first-aid. Give them a bandage and a shot and send them back. (#14)

Often in my first session I say, "Please let me help you understand. Therapy is not like what you see on TV. Let us go for reality-based here. This is what I can and cannot do. . . . If you have long-term stuff and you want to use your managed care benefit only, then it is probably not going to work out the way you hoped. (#15)

B. Therapists sometimes feel compelled to use types of interventions that they believe are ineffective. More than half of the participants (10 of 18) reported that managed care companies had pressured them to use treatment modalities that they regarded as ineffective.

Partly because of the demands of managed care, I have learned about and utilized more short-term approaches than I probably would have otherwise. . . . Frankly, I regard a lot of those things as pretty superficial and unsatisfactory, but I also find uses for them. They are useful tools. (#14)

I can remember sort of trying to be a little more behavioral in my approach. I'm not a behaviorist so that did not really fly. I just found myself feeling, "No, I cannot do this. I'm just going to have to do what I do." If it can work out in the short term, that is great, and if not, the client has had a good experience, one hopes, and may go on to find longer-term help. (#6)

¹ A copy of the full interview schedule is available from the authors upon request.

² In the excerpts, we have edited out dysfluencies (such as "you know," "like," and "um") and false starts. We use ellipses (. . .) to indicate that a phrase or clause has been omitted. In such instances, the omission does not alter the intended meaning. Occasionally, we have added material in brackets ([]) to clarify the interviewee's meaning. Verbatim text of the excerpted material is available from the authors on request.

Does my orientation fit with a managed care perspective? Absolutely not, underlined, bold. It does not. . . . Most of my training has been psychodynamic, but I think out of practical reasons, and I think for some good reasons also—for therapeutic reasons—I have had to become more savvy to more cognitive-behavioral strategies and to be able to talk more behaviorally. (#9)

C. Managed care companies may not authorize treatment for certain conditions. Twelve of the participants reported that managed care companies were too restrictive in authorizing treatment. Conditions that were too mild were sometimes disallowed, as well as conditions (such as personality disorders) that were regarded as too severe. Some participants argued that, by denying treatment for incipient problems, for disorders in their prodromal phase, or for many childhood and family problems, managed care companies squandered opportunities to prevent serious problems from developing.

Here's an issue: with young children, especially toddlers and preschoolers, you can see problems developing before a child can actually receive a diagnosis. And the *DSM* is really not made for kids that young. So it does not really capture the issues that are going on at that stage of life very well. Often you'll see stuff in a relationship between a parent and a baby or toddler. If you let it go for a couple of years, maybe a child will get Oppositional Defiant [Disorder]. (#7)

I know that they do not want to hear personality disorders. Like, forget it. . . . If you have somebody who has severe anxiety, an eating disorder and a personality disorder, the idea of bringing up a personality disorder as justifying treatment is just ridiculous. They do not want to hear that, they do not want to pay for that, so do not even bring that up, because that is going to make them less likely to approve. (#11)

I work with a lot of children who have developmental disabilities and pervasive developmental disorders, and once you give that diagnosis to managed health care, they're not going to cover anything, because it is not considered a psychiatric, a social/emotional/ behavioral disorder. It is developmental delay, there's no treatment for that. That is sort of the stance. (#9)

D. Under managed care, neither therapist nor client controls the length of treatment. More than two thirds of the participants (13 out of 18) noted this lack of control as an impediment to successful treatment. They often found themselves ending therapy before they judged the client was ready. Moreover, with the prospect of a precipitous termination always at hand, they changed their mode of conducting therapy.

Termination is by the numbers instead of by the outcome. I keep my eye on the number of sessions and as the number of sessions begins to run out, then I start to introduce termination. When we have 3 sessions left, let us talk about how we're going to focus work in the next 3 sessions. When I work with a private-pay client, often I do not suggest termination at all. I wait until the client suggests it. (#2)

If I know that I'm restricted to a certain number of sessions. . . I'll just tell the person, "This is what we can do in the time allotted." But I often feel that they should probably come longer. Psychotherapy takes time, and I really do not believe in the 10-session cure. (#14)

People lost their jobs or changed their jobs and their insurance coverage changed and they could not continue with therapy. That has happened a lot. (#18)

E. Implementing managed care policies can impair the therapist-client alliance. Eleven participants described ways in which strictures of managed care interfered with the therapist-

client relationship. For example, therapists were sometimes placed in the difficult position of conveying bad news to clients about their managed care coverage. Also, some therapists felt that adhering to the reporting requirements of the managed care company eroded clients' trust. Several therapists spoke of colluding with clients to misrepresent problems in order to gain approval for needed treatment or to protect the client's privacy. In short, the continual intrusion of managed care procedures and issues altered the therapist-client relationship, often in detrimental ways.

One of the things that is really difficult about managed care is that clients are told that you have 30 sessions in a year. They do not mean it! They do not want you to use all 30. So I have clients saying to me, "Well, what do you mean that they were hesitant to authorize Sessions 15 to 20?" Well, because they are. And so what I say to clients is, "Unless you are willing to let me emphasize the negative parts of our work." That is how you get the most sessions. But they do not like that. I mean, the companies do not like it, and the clients do not like it because they feel, "Then why does it say that?" I say, "You can take that up with HR [that is, the Human Resources department at the client's workplace]. I'm just telling you the reality." (#15)

I'm seeing a 19-year-old, and I did not really want to tell the insurance company that he was smoking marijuana. That really gets murky in terms of your liability and what you have to report. It is hard to get somebody's confidence when they feel like you are going to be ratting on them. So it just adds something else into the mix when you are already dealing with a difficult situation. (#1)

F. Some managed care plans require procedures that interfere with the conduct of therapy. Eleven participants described procedures required by managed care companies that interfered with their usual conduct of therapy. How these intrusions into the therapy process affect outcome is unknown; however, therapists found them heavy-handed at best and destructive at worst.

I think treatment plans are great, but the kinds of things they force you to do where everything has to be allegedly measurable, it drives most therapists absolutely crazy. I used to hate doing those because I felt really sort of fraudulent. Not because the goals were not important. They were things we were working toward—but it often made it look as if one was going to get there faster. . . You'd see a problem that was of long standing and you'd have to think of this short-term measurable goal. Sometimes it really felt like a very itchy jacket or maybe a straitjacket. (#6)

In psychoanalytic psychotherapy, the idea of every 5 or 10 sessions saying, "What are our goals and how far have we met them?" would be just nutty, just completely destroy the process. I'm not saying that there is not a process of reflection. There is. But it is done much more subtly than that. (#5)

Summary. Participants' descriptions of their experiences left little doubt that, for them, therapy under managed care entailed significant departures from their best practices. For example, they were sometimes required to use unfamiliar approaches. Often they had little faith that they could achieve positive outcomes within the parameters set by the managed care company. There are, of course, both ethical and practical reservations to offering therapy under such conditions. Also, the omnipresent possibility of precipitous termination affected both therapy content and process. Moreover, continual surveillance by managed care personnel changed the nature of the therapist-client relationship. For those forms of therapy in which the therapist-client relationship is key to thera-

peutic change, this was not only an unwelcome intrusion, but also an impediment to the therapeutic work.

Nearly every participant took issue with the restrictions that the managed care companies often placed on the types of diagnoses, problems, or clients eligible for reimbursed care. In our view, these are not merely disagreements over details; they point to a fundamental clash between psychotherapeutic culture and the culture of managed care. Most participants subscribed to an ethos of care that focused on a holistic view of the person. Their clinical understandings involved complex formulations that drew upon elements such as personal character, moral personhood, social relations, and personal growth. They took a long view in which prevention of future difficulties was a valid goal. In contrast, the ethos of managed care, as they experienced it, took a narrower and shorter-term view. It focused on medicalized diagnoses with little reference to the whole person or the social context. Its goals rested on thin, even superficial, behavioral criteria and symptom remission.

Demands for information. The second overarching theme regarding the impact of managed care on therapists' work concerned the continual demands for information that managed care organizations made. Many participants resisted demands that they transform their understanding of the client into the language of *DSM* diagnoses (as required by managed care representatives) because they found that language inadequate and reductive. In addition, many participants struggled to find ways to protect clients' privacy while meeting the companies' demands for detailed information in progress reports.

A. The difficulties that clients brought to therapy did not fit within the diagnostic framework imposed by managed care companies. More than two thirds of the participants (13 of 18) mentioned difficulty translating clients' problems into diagnoses acceptable to managed care organizations.

Like the V-codes. I used to use them all the time. . . . The insurance companies rejected all the V-codes, so no one used them anymore. Then there's one insurance company that sent around a list of insurance codes they will not accept, which is a problem. Some of the diagnoses that are commonly used are on the list. So I discussed with a psychiatrist, you know, "What are we going to do on this case? They have ADD, but ADD is not acceptable. What do we say?" We came up with a Not Otherwise Specified diagnosis. (#12)

Diagnostic categories do not exist for couples and treatment codes do not exist for couples. It poses particular problems because the insurance model is a medical model, which is an individual model. . . . One person, one diagnosis. There's no diagnosis for a couple's sex problem, so then you have to find some reimbursable diagnosis that works. A long time ago, I decided I would use a very vague diagnosis of Adjustment Disorder. (#18)

B. Managed care's demands for information must be weighed against clients' rights to privacy. Eight therapists described situations in which they or their clients were concerned about reporting information to managed care representatives. This was true not only about initial diagnoses, but also about progress reports throughout therapy. Concerns about privacy pertained to current and past information about clients and sometimes to information about others, such as family members or spouses.

She really did not want her history of incest in her family revealed on that questionnaire and her father's physically abusive behavior with her mother, and yet they [the managed care representatives] were

saying, "Why is she having trouble building a relationship with a man?" and so forth. "Why is this situation so intractable?" (#13)

C. Concerns about privacy can weigh heavily in clients' decisions to enter or leave therapy. Four participants reported instances in which concerns about privacy prevented clients from entering therapy or led them to terminate prematurely.

The other problem is sex [a sexual disorder] being a stigmatizing diagnosis. I think that keeps people from coming to therapists with that kind of problem more than it ought to. Like how an eating disorder is stigmatizing, but a sex disorder seems more stigmatizing. (#18)

I think it was a factor, not the only factor, with her withdrawing from the therapy, because the managed care company was getting more and more intrusive, and she did not want to reveal the serious history that she was coming into therapy with. (#13)

Even though there are ethics of managed care, there's also a huge rumor mill out there. A lot of people have heard horror stories—whether they're valid or not—of all their managed care information going to their personnel department or this or that or the other thing. So a lot of times people will say, "Well, can I see you and just pay out of pocket and not use my insurance, because I do not want to risk certain things?" (#8)

Summary. Many participants walked a tightrope in their communications with managed care personnel regarding their clients. On the one hand, they had to describe a client's condition with sufficient urgency and gravity that reimbursement for treatment would be authorized. On the other hand, concerns about privacy made them reluctant to put damaging information into a record they believed was "leaky." Furthermore, they often struggled to reformulate a client's difficulties in order to gain treatment authorization without crossing the line into outright lying and potential insurance fraud.

Although no participant commented on it directly, it was clear from the interviews that the participants were spending substantial amounts of time during therapy sessions talking with clients about managing (and massaging) information for managed care representatives. Many participants talked over the ramifications of various diagnoses with their clients before submitting paperwork to an insurance company. Some read the *DSM-IV* with their clients and together chose a diagnosis that the client found acceptable. Sometimes therapists and clients discussed together which aspects of the client's background and history could or should be concealed. For example, some therapists reported that gay and lesbian clients feared that their sexual orientation would be revealed to their employers; one reported that people with problems of sexuality and gender identity did not want these entered into their insurance files. Some clients did not wish to disclose objectionable behavior of others (e.g., an incest victim wished to protect her family's reputation). Over the course of therapy, therapists and clients needed to discuss repeatedly what information might be disclosed. Prior to the advent of managed care, such negotiations, of course, were not such a prominent part of the therapeutic process. How do they change the therapy process and the therapist-client relationship? Do they help or hinder clients' progress? When such negotiations border on frank misrepresentation of clients' diagnoses, what are the moral and ethical implications? With so few sessions allotted for treatment under many managed care

protocols, it is ironic that a considerable amount of time in sessions must be given over to such negotiations.

II. What Differences Do Therapists See in Clients Who Enter Therapy Through a Managed Care Plan?

We did not ask direct questions about this topic in the interview, yet several participants spoke about it. A central theme of their remarks was that clients' conversations with managed care personnel led them to misunderstand the nature of therapy.

A. Managed care directives led clients to a misunderstanding of therapy. Twelve of the participants registered concerns that communications from managed care personnel led clients to an understanding of therapy that was at odds with that of the therapist. In addition, clients often assumed that the number of sessions that was authorized was the number sufficient for a cure.

I think it has made people more passive in their approach and that has changed their relationship to the process. It has made it a very medicalized, short-term thing in their minds and I think it goes against the grain of what therapy ought to be. (#5)

There's sort of a sense of, well, gee, my company sent me here for three sessions, and yeah, okay, there are my three sessions. Now are we done? . . . I guess it is more like they're coming for a procedure rather than a process. (#8)

B. Clients regard therapy as a purchasable commodity, not a collaborative process of change. Half of the participants reported that clients had been given an inappropriate understanding of their part in the therapy process.

I try to alert them that this is a responsibility that they're taking on. I think too much of what has happened, and this is not simply managed care, but insurance in general, is that it has created an unconscious mindset that, "We're going to get what the insurance pays for. If it does not pay for it, we're not going to do it." I try to alter that. (#3)

The worst managed care plans are the ones where people do not have to pay a buck. I do not like those. It does not feel like I have as much success as with one where people are paying 10 or 20 dollars [as a copayment]. . . . Some people, we cannot work together because they're so not invested in doing their homework and showing up when they're supposed to because there's absolutely no cost to them. There's lots of cost to me. Sometimes it is financial, sometimes it is that you wasted a spot. (#15)

A lot of people do not finish what they start. They feel better, but they do not get well. . . . I have a patient [whose insurance] happens to pay for unlimited visits with no copayments. She's going to work at things until it is done, as opposed to somebody else who knows that 5 months down the line, they may have to stop therapy and come back 7 months later. That is going to impact the outcome. (#3)

C. Some managed care plans discourage clients from taking an active part in choosing their therapists. Ten of the participants expressed concern that clients did not take an active part in choosing a therapist. Instead, they simply went to the therapist whose name was supplied by their insurance company.

Before, people seemed to have more traditional insurances. So they were going to pay out of pocket or they were going to use their insurance. So they could go wherever they wanted and use their insurance. So it was about that time—the mid 1990s—that people sort of started having less of a sense of I'll decide where I go based on

reputation or word of mouth or even the yellow pages versus I'll go to this list of people that people tell me to go to. (#8)

People sometimes approach therapy the way they approach their dentist. People come who know nothing. "I've been given your name. You are my therapist." (#5)

Summary. According to many participants, managed care personnel imparted expectations about therapy that were detrimental to treatment. For example, managed care personnel described therapy as if it were a time-limited, one-size-fits-all procedure akin to a dental checkup. Some companies set the number of sessions even prior to diagnosis. Practices like these denied the need for clients to take an active part in the therapy. This view of therapy was sharply at odds with that of our participants. Regardless of their therapeutic orientation, these therapists saw therapy as an open-ended, collaborative, human encounter. From the standpoint of a managed care company, however, the bureaucratic procedures it imposes are efforts to rationalize an otherwise unruly and unpredictable endeavor. Such procedures are necessary to predict and contain costs. This is another dimension of the clash of culture and philosophy between many forms of psychotherapy and at least some forms of managed care.

Some participants noted that managed care personnel simply assigned a therapist to a client, implying that the fit between therapist and client was immaterial. This brings to mind Cushman and Gilford's (2000) caveat, noted previously, that under managed care, therapists come to be seen merely as impersonal dispensers of predetermined techniques. Moreover, such policies undermine the goal of fostering clients' autonomy and self-determination, a goal that is central to some forms of therapy, such as feminist therapy. Apart from that, there is a pragmatic concern as well. At least one study has found that clients whose choice of therapist was limited by a managed care company reported less progress in treatment (Seligman, 1995).

In another vein, it was in respect to client populations that most of the scant positive comments about managed care were made. Four participants noted that managed care plans made therapy accessible to a broader range of individuals, including more working class people and people of color. In addition, two participants noted that participation on managed care panels provided them with an adequate referral base.

III. Managing Managed Care: Therapists' Strategies of Resistance

What do therapists do when the conditions of work imposed by managed care companies violate their standards of good care or their professional ethics? None of the participants in this study simply acceded to the strictures of managed care companies. Instead they devised numerous strategies to live up to their professional and ethical standards in spite of the constraints of managed care. We describe the five practices mentioned most frequently.

A. Emphasize the negative aspects of a case to keep reimbursements flowing. Eleven participants described ratcheting up the seriousness of clients' diagnoses or "hanging crepe" in order to secure more sessions of therapy.

Everybody is in crisis. . . . In other words, the crisis may not have happened in the same time frame I said. So let us say I've had 5 sessions with you and during that time somebody in your family got

sick. Well, I might wait until I need more sessions [and then say to the managed care person], "Oh, you know she called me and I really need to schedule her. She just found out her mother got a diagnosis." You do not make up the crisis. You just share it with them in a timely manner that works to help you. (#15)

I know my own therapist gave me [a diagnosis of] Adjustment Disorder because you have to have a disorder and said, "This is going to be covered for a certain number of sessions, and if you want more sessions, you have to have another disorder." I said, "I do not want that. Major depression? Forget it." Up the diagnosis, that is his strategy. (#7)

In order to get treatment, you sometimes have to hang crepe. You have to make it bleak, really bleaker than it is. (#17)

B. Frame the client's situation in terms of cost containment. Seven therapists took pains to couch requests for continued treatment in terms of saving money for the company.

When I had clients who I knew were self-destructive, I always made a point of talking about how we were keeping them out of the hospital and what we were trying to do. It was true but it was important to state and to talk seriously or write seriously about self-destructive behavior and suicidality because I always knew they were looking at the bottom line and that was the question: Is this the cheaper way to go? (#6)

C. Reframe clients' problems and progress using the language of managed care. Most of the participants (13 of 18) reported that they self-consciously adopted the language of managed care when speaking to company personnel.

Basically telling them what they want to hear the way they want to hear it. For them to say, "Okay, then, we'll allow it." I'm not saying misrepresenting information or lying or anything, but I just know what the buzzwords are, the things they want to hear, and the things that they do not want to hear. (#11)

D. See clients for free when managed care companies have denied urgent care. Thirteen participants occasionally had seen clients for free when the urgency of a situation demanded it. Either they or the hospitals and clinics where they worked absorbed the unreimbursed costs. One participant recounted a case that involved a psychotic and suicidal adolescent whose parents were unavailable to provide care. She went on to say:

It struck me so deeply: The lack of protection. People pay for insurance and then they do not have it. And it can be capriciously denied. . . . This was a boy who I just kept in the hospital. We never got paid. (#17)

I've seen people for free. Like we're not charging now for anything that we're doing. Kids who come through the ER, if they really need to be hospitalized and the managed care company will not approve it. . . . It is very expensive for the hospital and the hospital eats the cost. A lot of hospitals are really struggling right now. (#5)

If people need to be seen, I see them. I'm just doing my income tax and I get restless with the number of free hours I've given away during the year. . . . If I want to be satisfied with my work, then I have to be willing to eat the cost of that on occasion. (#17)

E. Do as little managed care work as possible. Most of the participants tried to do as little managed care work as they could. Some accepted managed care clients only in slack times, such as summer. Some articulated ultimatums: "If they ever ask me to do

that, I'll quit." Many looked forward to the time when they would be established enough to step off managed care panels entirely.

The best therapists would not work under these conditions. You get what you pay for, or rather managed care gets what it pays for. (#5)

Summary. Many participants actively subverted some managed care policies that they regarded as unethical or violating professional standards. Their strategies of resistance enabled them to live with managed care but it was a strained relationship. Moreover, such strategies necessarily involved accommodating to the system as well as resisting to it, as this reflective therapist suggested:

Well, my ethics bind me to say that I practice the same [whether or not a patient is being seen under a managed care plan] and that I do not capitulate to managed care and I do what the patient needs, and so on. But you change your view of what the patient needs with managed care patients, because sometimes you are doing your best compromise to get for them what they need given the constraints that they are under. (#5)

Like Therapist #5, we worry that speaking the language of managed care, adapting to its culture and worldview, and adjusting to its treatment ethos inevitably will alter how therapists think about therapy, their clients, and themselves.

Conclusions

Our analysis was not intended to uncover universal truths about managed care or to document representative practices of managed care companies. Nor did we aim for generalizations about how all therapists respond to managed care. Rather we bring forward the perspectives, daily experiences, and points of view of a small number of therapists struggling to live up to their ethos of clinical care and professional integrity within the context of managed care. We bring forward their accounts at a time when some might claim that "all the fuss" about managed care has died away and there is no need for reviving earlier contentious discussions. Managed care, however, was by no means a settled issue for our participants. It remained an emotion-laden topic, with participants registering exasperation, disdain, distrust, and sometimes demoralization. Their responses square with those reported in a recent study comparing surveys of therapists carried out in 1996 and 2001, which found little improvement in therapists' work-related stress and their ratings of satisfaction (Rupert & Baird, 2004). For our participants, the root of the negative emotions was a fundamental incompatibility between their ethos and what they understood to be the guiding philosophy of the managed care companies they worked for. Although participants had found means to subvert or "work around" many policies of the companies, the standards of care of the managed care companies remained at odds with their ideal of good care. Although Rupert and Baird (2004) consider this lack of fit mainly in terms of workplace stress, we think it is vital to consider it as a conflict of differing worldviews, differing concepts of the person, and differing ideals of psychological health.

Working within managed care systems also generated ethical problems for most of our participants, as it did for large numbers of therapists in the large-scale surveys we reviewed earlier. A primary arena of ethical concern was the flow of and control over information about clients. In communicating with managed care

personnel, the moral calculus of our participants was not whether or not to misrepresent clients' conditions, but instead what degree of misrepresentation was ethically acceptable. One participant, for example, described himself as "always playing at the edge of reality." Another participant, a therapist who worked with couples, asked the couple to "decide who wants to have [the diagnosis]." One participant believed that even flagrant misrepresentations were justified because managed care companies "cheat" clients out of benefits rightfully due to them. For the other participants, however, the choice between providing clients with adequate care and providing companies with truthful diagnoses and progress reports repeatedly posed ethical dilemmas. An additional ethical dimension—one which participants themselves did not seem to recognize—concerns the common practice of colluding with clients in embellishing or misrepresenting their difficulties to gain additional benefits, thus modeling dishonest behavior.

Providing information to clients was another area of ethical concern for many participants. Some companies imposed "gag rules" that forbade therapists to inform clients that authorized amounts or types of treatment were inadequate. Such gag rules required therapists to pretend that a course of treatment in which they had little confidence would succeed, a course of action that some therapists found ethically reprehensible. As novel ethical challenges unique to managed care arise, guidance from the ethics committees of professional associations would be welcome. Indeed, such boards might even take proactive steps such as issuing policy statements (or perhaps even initiating lawsuits) that challenge policies of managed care companies that are frankly outside the bounds of ethical practice.³

Many commentators have registered concerns that therapists working under managed care come to take *DSM* diagnostic categories too seriously, substituting them for detailed, specific, and nuanced knowledge about their clients. Discussing managed care, Wylie (1995), for example, ruefully referred to the *DSM* as the "bible" of psychotherapists. Our participants' accounts suggest something quite different, however. For them, diagnoses seemed to serve as little more than bargaining chips for gaining reimbursement. One therapist, for example, referred (without irony) to a *DSM* diagnosis as "the number you have to write down to get paid." Others, as we have seen, assigned diagnoses in accord with a variety of purposes other than treatment planning. We worry that the diagnostic language games practitioners feel compelled to play will empty diagnostic categories of any content or clinical utility. Furthermore, when practitioners draw their clients into these language games, the credibility of the profession erodes and public confidence in its knowledge base diminishes.

Our participants' dissatisfaction with managed care was palpable, as was their longing to be free from it. Apart from an expanded pool of therapy clients, the only positive attribute of managed care (noted by three participants) was that it made therapists more efficient and accountable. Most participants did as little managed care work as possible. Several believed that any therapist would leave managed care as soon as she or he had an adequate private pay caseload; this was their long-range career objective. If such attitudes are representative, we might anticipate that managed care companies will end up with a workforce of inexperienced or less skillful therapists. These therapists will provide the bulk of mental health care, while established and effective therapists will treat clients who can pay out of pocket. Such a two-tier system is not

what the advocates of managed care intended, nor is it consistent with the aspirations of the therapy professions.

The management of psychotherapy is the most profound transformation in the history of psychotherapy. Yet psychologists thus far have researched only limited aspects of it, such as therapists' attitudes and factors like fee reductions and job satisfaction. Studies of the ways that managed care affects clinical care have been left mainly to anthropologists and sociologists (such as Donald 2001, Luhrmann, 2000, and Ware et al., 2000). Our study has taken a first step toward understanding how the "inside" of psychotherapy is transformed by managed care by inquiring into therapists' reflections on therapeutic processes and client-therapist relationships. A next step is to study directly—whether with ethnographic methods or quantitative methods—specific practices mandated by managed care and actual therapy processes, outcomes, and relationships. Our study, we believe, offers many intriguing directions that such studies might take.

³ A recent example is the lawsuit instituted by the Virginia Academy of Clinical Psychologists Association against a managed-care company that the VACP accused of fraud.

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