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A Comparative Study of Factors Outside the Therapy Room Influencing Therapeutic Practice in The United States and Norway

Objective. The goal of this thesis is to describe the experiences of psychotherapists in the United States and in Norway in dealing with the outside influencers, namely managed care organizations (MCO) in the United States and governmental bureaucracy in Norway. Research on managed care and the therapeutic process in the United States has not been given much attention since the turn of the century, and due to the recent arrival of governmental influence on psychotherapeutic practice in Norway, a matching research picture does not exist. Therefore, this thesis represents a pilot research project seeking to bring to light the experiences of Norwegian psychotherapists, and re-open the discussion of the effects of managed care in the United States.

Methods. Interviewees were selected through word-of-mouth and "cold-call" emails. Semi-structured interviews were conducted with seven mental health practitioners, three from the United States, and four from Norway. All of the interviewees, from both countries, have been in practice on average for more than 20 years. Thematic analyses were conducted to discover the underlying themes, and great care was taken to ensure the interviewee's anonymity through the use of pseudonyms.

Results. Interview analyses revealed a number of themes. American psychotherapists discussed issues with joining a managed care panel and maintaining membership, adjusting their practices to fit managed care requirements, qualifying and advocating for their clients' treatment, and working around the managed health care system. Norwegian psychotherapists discussed governmental control and their new rules for practice, efficiency standards, the government's power to support and limit their practices, pressure from the outside, and the strong voice of the therapist. Interviewees from both countries similarly mentioned the distinction between public and private care, paperwork, and justification and opposition for their respective systems.

Conclusion. The results of this study revealed a major distinction between American and Norwegian psychotherapists. Because American psychotherapists adjust their practices to fit the demands of the MCO, they have given up much of their autonomy, and have become "robots." Conversely, because Norwegian psychotherapists use the power of their voices to speak out against the new governmental practices, they retain greater control, and act as "pilots" navigating in their therapy rooms.

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Chapter 1: Introduction to the study

1.1 Statement of the Problem

Roughly 30 percent of Americans between the ages of 15 and 54 suffer from a psychiatric disorder every year (Metzl 1998). In addition, about 50 percent of the same population will meet criteria for mental illness over the course of a lifetime, however, less than 40 percent of them will seek treatment (Metzl 1998). In Norway, life-long prevalence of depression is 15.6 percent for women and 19.7 percent for men, however, only 7.5 percent seek out treatment (Bang-Nes and Clench-Aas 2011). Those who do seek treatment are offered a special opportunity to confront and repair life's most difficult situations through the development of the client-therapist relationship (Edward 1999):

> For many individuals their encounter with their therapist may be their first opportunity to engage with someone who is there for them in a constant, reliable way; who is interested, respectful of and attentive to them; who helps them give words to and gain understanding of that which they have previously found perplexing or overwhelming; and finally their first chance to experience a person who can tolerate their most uncomfortable thoughts, feelings and sometimes their most provocative and vexing behaviors (89).

Since the 1980s, this traditional form of relationship development has made way for a new dominant force, one in which that manages and controls the delivery of mental health care services: managed mental health care (MMHC) (Cushman and Gilford 2000). Indeed, MMHC is a system comprised of large for-profit organizations that cover roughly 78%, or 176.8 million Americans (Fox and Garris 1999). MMHC is an attractive service because of the less expensive alternatives they offer in lieu of otherwise high-cost pay for service systems (Relman 1988).

As such, managed care (MC) was designed to contain and reduce costs and regulate price (Shaw-Austad and Hoyt 1992). In fact, "managed care has been presented to the public as an effort to enhance the … efficiency of treatment" (Roback et al. 1999, 2). While MC was established in order to diminish cost and improve care, previous research shows that MC is very different in practice. Because consumers seek to purchase quality care and convenience at minimal cost, they are

encouraged to view health care as a commodity that the payer has a right to purchase (Shaw-Austad and Hoyt 1992). In addition, mental health care benefits are typically less generous than physical health care benefits (Kee and Overstreet 2007), choice of treatment is determined by case reviewers, and the client's autonomy is compromised through the use of quality assurance and utilization review tactics managed care organizations (MCOs) use in order to maintain profits and contain costs (Wineburgh 1998); the client's needs become secondary, and the quality of care and long-term outcomes become less prioritized (Karon 1995).

Indeed, as MCOs begin to focus more on cost and less on care, essential services are cut and quality declines (Miller 1996). This typically occurs through the application of the monitoring tactics the MCO uses including preadmission screening, treatment authorizations, medication compliance, and treatment plans (Wineburgh 1998). Furthermore, MC has altered traditional psychotherapy by introducing a third party into the therapy room, the case manager (Krischner and Lachicotte 2001). These nonprofessionals are given the power to decide who gets treatment, and for how long (Krischner and Lachicotte 2001), and are "held above doctor and patient like an invisible hand" (Metzl 1998, 341). Thus the client-therapist dyad becomes a complicated triad with the clinician and the MCO at odds, as each have their own assumptions and goals for therapy (Wineburgh 1998).

Because the MCO has a constant presence in the therapy room, the client and therapist are never alone, and the goals of therapy shift from the client's needs to the requirements of the insurance company (Metzl 1998; Edward 1999). As such, the type of alliance that develops out of longer term therapy is made impossible, and in its place, a manufactured relationship built upon MCO procedures emerges (Cushman and Gilford 2000). Corporate reform has led to the impingement of traditional therapy and has damaged the integrity and quality of care. (Rothbaum et al 1998). In addition, because MCOs determine the who, what, and when of treatment, ethical and social concerns start to emerge when less than ideal patients are denied treatment because their needs do not coincide with the MCO's treatment philosophy. (Wineburgh 1998; Shaw-Austad and Hoyt 1992) Indeed, MCOs frequently deny claims, restrict access, employ less than average providers, and regulate treatment with intrusive assessments, behaviors that otherwise suggest that MCOs treat mental health care coverage as an entity to steer clear from at all costs (Metzl 1998). These practices ultimately limit contact between the clinician and the client, suggesting that managed care

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is not compatible with psychotherapy (Roback et al. 1999). As such, MC regulations do not match clinicians' perceptions of their patients nor the course of therapy (Krischner and Lachicotte 2001) causing many clinicians to argue that MCOs homogenize not only the delivery of services, but also the basic understanding of mental disorders with labels such as 'acute', 'active', and 'maintenance' (Krischner and Lachicotte 2001). Thus, MC does not respect the distinctive and differing characteristics of psychological illness, and ultimately, the field of psychology itself (Krischner and Lachicotte 2001; Cohen, Marecek, and Gillham 2006).

In spite of the overwhelming anecdotal evidence of psychotherapists voicing their dissatisfaction over MC's incompatibility with effective mental health treatment, very few empirical research studies have explored the experience of the MMHC provider in the United States. On the other hand, new governmental regulations and policies in Norway are so fresh that there has not been enough time for the empirical work to catch up. As a result, the Norwegian literature is non-existent. Whereas in the United States, we see that the number of studies exploring this topic have diminished since the turn of the century, suggesting that American mental health care providers have become accustomed to the managed care method of treatment. Furthermore, the few empirical studies that have examined the compounding effects of MC on the provider have been quantitative in nature, leaving little room for therapists to provide fruitful descriptions of their own experiences in their own words. The present study addresses these deficiencies and contributes to the literature by giving these otherwise unheard voices a stage to be heard within an appurtenant time period.

Thus, the question for mental health practitioners, policy makers, and managed care personnel alike is how do regulations and restrictions placed upon mental health care providers affect one's ability and duty to provide efficient psychotherapy when a third entity enters the therapy room?

1.2 Purpose of the Study

The purpose of this study was to describe mental health care practitioners' experiences with outside third party influences in the United States and Norway, and to explore the impact of these factors on the ability of practitioners to provide services. Semi-structured interviews and a phenomenological design were utilized resulting in a context-bound phenomenological description of the individual's direct experience. Third party influence is defined according to geographical

location: In the United States, the outside third party is managed mental health care, and in Norway, various agencies of the Norwegian government.

1.3 Research Questions

The main research question for this study was: (1) How do mental health clinicians perceive the impact of third-party entities on their practices? In addition to the main questions, several sub-questions follow: (a) How are the experiences of Norwegian and American mental health care providers similar and how are they different; (b) how do these entities affect their ability to treat their patients; (c) how do mental health care providers adjust their practices in order to comply with third party rules and/or regulations; (d) how does compliance affect mental health care providers' ability to provide quality services; and (e) how do mental health care providers advocate for their clients? Their practices? Themselves?

1.4 Delimitations and Limitations

The first delimitation for this study was length of practice; all mental health clinicians who were interviewed must have had experience practicing therapy prior to the implementation of managed health care (in the United States) and governmental rules and regulations (in Norway). The second delimitation that arose out of this first requirement was that all informants must have had therapeutic experience as a practitioner, meaning that they had held therapy hours with clients either currently or in the past. The third and final delimitation for the study was that the interviewees must have had experience working within either the managed care system or the Norwegian public health system, depending of course on their location and nationality.

According to Creswell (1994), qualitative research involves researcher interpretation. As a result, researchers introduce their biases, values, and judgments into the design and implementation of their studies, which in turn, limit their studies. The current study is also limited in a similar fashion as I, the researcher, have designed this study with negative preconceived notions connected to managed care and other types of restrictions that limit the work of mental health practitioners. Finally, the second limitation for the research at hand is the small sample size that I have chosen to represent the mental health clinician population. As such, my research is not only context bound, but it has also very limited generalizability.

1.5 Significance of the Study

This study is significant for researchers, mental health practitioners, and policymakers alike. First and foremost, this study is unique because it not only expands the out-of-date literature in the United States, but it also renews the relevance of the topic. In addition, since no similar research has been conducted in Norway prior to this study, this study provides a new set of data for those who wish to divulge this topic further in the future. Another significant feature of this study for the researcher is the qualitative method I have employed. Using qualitative data creates a new perspective for the field because those whose work is affected by the rules and regulations that are required of them are given the chance to speak out about their experiences.

This study is not only significant from an empirical perspective, but it is also significant for the practice of mental health itself. Psychotherapists in the United States have an opportunity to gain a better understanding of MC experience, and in turn, develop the means necessary to effectively manage managed health care. In addition, having a discussion about third party limitations will improve care standards and prevent harm. As for Norwegian psychotherapists, this study is useful in the proactive resistance they engage in against the increased control they have experienced over the past decade (see 'findings' section). Overall, practitioners from both countries can use this study as a means to develop better ways of managing their practices and treating their clients.

Finally, this research is significant for policymakers. While it may be wishful thinking that the United States could create and implement an exhaustive medical care-for-all policy, this research study does indeed bring awareness to the need for reform. The psychotherapist's perspective creates a unique opportunity for policymakers to learn how managed care in the US limits their ability to provide services and treat their patients. In addition, American policymakers are given the opportunity to understand what mental health care looks like in other affluent democracies around the world, and in turn, how an effective care-for-all policy is accomplished. Norwegian policymakers will also benefit from this research as the American method of care is introduced and explained. In return, Norwegian politicians are provided with an example of a flawed mental health care system that they can strive to prevent.

This thesis will first focus on what previous research in the United States has shown about MC and its effect on psychotherapy. Due to the recent arrival of governmental influence in the therapy room in Norway, a matching research picture of outside influences in the Norwegian therapy room does not exist. In one sense, this thesis is a pioneering project which seeks to provide evidence about the new therapeutic atmosphere for psychotherapists in Norway. From there I will describe the methodology of this study, and then present the results of my conversations with American and Norwegian practitioners. Next, the guiding theoretical perspectives of this project and the findings of this study will be discussed. I will then end this paper with a short conclusion.

Chapter 2: Literature Review

2.1 Traditional Therapy

Generations of early mental health practitioners were taught that the main focus of psychological treatment was to provide therapeutic services to its users (Fox, Lessler, and Cooper 2000). In addition, according to Kirschner and Lachicotte (2001), psychotherapy serves as a means to enrich individuals through the development and expansion of one's skills and strengths. Furthermore, good psychotherapy is preventative in nature, and prepares the person to counteract life's toughest moments before they evolve into more serious problems (Kirschner and Lachicotte 2001). If an individual is unable to effectively manage life's difficulties, symptoms develop, causing what some call a developmental crisis (Cushman and Gilford 2000). A developmental crisis requires direct therapeutic intervention; this intervention must occur long enough to lead to a reduction in symptoms, and allow the individual to return to a normal level of functioning (Cushman and Gilford 2000). In the early days of psychotherapy, an individual in the throes of a developmental crisis was referred to a professional through someone they were familiar with and had a great deal of trust in (Edward 1999). In this day in age, the referral process has evolved into a much different arrangement; referrals are often arranged according to zip codes, thus undermining the once trustworthy process of matching client with therapist (Edward 1999).

According to Roback et al. (1999) the client-therapist relationship "is everything. If there is no relationship, there is no treatment" (7). Indeed, the client-therapist relationship was recognized by Freud himself (Edward 1999) stating that positive transference is key in the development of

attachment (Friedman 1988). The development of the client-therapist relationship is no doubt an important aspect of good psychotherapy, however, establishing said relationship is another story. According to Carkuff (1987), in order to establish the counseling relationship the style and the characteristics of the client must be considered. Furthermore, pressure and confrontation can jeopardize its development (Rogers 1980). Overall (Edward 1999):

> The development of a therapeutic relationship depends upon the contributions of both partners. The patient must be able in some way to engage with the therapist…. The therapist … helps foster a relationship by his or her non-judgmental, non-authoritative, non-intrusive, and benign approach. By involving the patient as much as possible in the process, by respecting his or her right to self-determination, and by carefully guarding the patient's autonomy, a clinician seeks to create an atmosphere in which the patient can feel safe enough to risk involvement with another person. (89)

The research literature indicates that protocols enforced by MCOs are designed to save the corporations money, however, this economic desire thwarts the time and space clinicians have to establish and nurture the all-important therapeutic relationship (Kirschner and Lachicotte 2001). Therapists and researchers alike argue that the economy of managed care ensures that a closed, two-party discussion is impossible (Metzl 1998). Furthermore, the knowledge, understanding, healing, and change that emerges from the two-party discussion between client and therapist is dependent on "the flow of agency within the room" (Metzl 1998, 340), and is thus incompatible with MCO guidelines.

Pre-managed care pay-for-service treatments allowed clients the freedom to express their need for services, select their preferred provider, and participate in the counseling process (Wilcoxon, Magnuson, and Norem 2008). In turn, this created a sense of loyalty in the professional, and emphasized the professional's expert knowledge in their ability to develop and implement treatment strategies (Wilcoxon, Magnuson, and Norem 2008). Today, the traditional views of therapy, the referral system, and the development of the client-therapist relationship has given way to the cost-containment delivery methods of MHC (Gerig 2007). Indeed, the introduction of the MCO into the therapy room has brought about changes in psychotherapy including the introduction

of a limited number of sessions, treatment style and goals, and the expectation of rapid client change (Cohen, Marecek, and Gillham 2006; Gerig 2007). All of which lead clinical professionals to label MC as the 'Walmart-ing' of psychotherapy (Cohen, Marecek, and Gillham 2006). Reflecting on the traditional views of psychotherapy reveals an independent system that fought to classify therapeutic services as a medical necessity (Shaw-Austad and Hoyt 1992). Now that these traditional views have given way to a medical health care system (Brown 1983), psychotherapists are forced to accommodate to this new alliance and allow the outside third-party into the therapeutic relationship (Shaw-Austad and Hoyt 1992).

2.2 The History of Managed Care

During the 1960s, prior to the MMHC movement, psychotherapy was believed to be the 'Cadillac of professional services' due to contract accessibility and the convenience it provided (Fox, Lessler, and Cooper 2000). However, because psychotherapy was paid for out-of-pocket, inequalities in access to services began to emerge; those who could afford to pay had access to the most qualified and experienced clinicians, leaving the less fortunate to seek treatment from less experienced clinicians (Fox, Lessler, and Cooper 2000). During the 1970s and 80s, psychotherapists took to the MC movement because of its promise to deliver high quality services to those who needed it the most, its accessibility, and its cost-effectiveness (Shaw-Austad and Hoyt 1992). In addition, the number of health plans that recognized mental illness as a covered condition skyrocketed, allowing psychotherapy to be accessible beyond only those who had the luxury to pay for services (Fox, Lessler, and Cooper 2000). As a result, more and more psychotherapists working within community clinics became MC providers, however, public health programs were also being reduced or eliminated at this time, causing psychotherapists to rely solely on psychotherapeutic treatment as their source of income (Fox, Lessler, and Cooper 2000). Eventually, this resulted in complete dependence upon insurance reimbursement instead of the public funds that had been supplementing their practice during the 1960s (Fox, Lessler, and Cooper 2000).

After the approval of the Health Maintenance Organization Act of 1973, managed care grew rapidly as a means to control escalating health care costs and decrease the number of uninsured Americans (Riffe 1998; Kee and Overstreet 2007). Indeed, health care costs expanded from 6% to 12% of the United States' gross national product between 1965 and 1990 (Miller 1996). According

to Fox, Lessler, and Cooper (2000, 53), "the managed care agreement marked the beginning of the most rapid change in the region's health care market that had ever been seen." Furthermore, collaborative relationships between providers flourished, higher standards of care were established, patients were given better integrated care, and conflicts between clinicians were easier to regulate (Fox, Lessler, and Cooper 2000). During this short period of time, MC seemed to be the fix-all solution to provide high quality care to the masses, however, a pressure to save money emerged which decreased health care spending and increased the profits of the health care corporations (Fox, Lessler, and Cooper 2000). The expert reviewers became case managers that controlled approvals and demanded detailed accounts of what transpired during therapy hours, bringing the issue of confidentiality to the forefront (Zuckerman 1989). Long-term treatment options, such as psychoanalysis, were replaced with short-term therapy and medication, work load increased while incomes dropped or remained stagnant, and overhead profits soared (Fox, Lessler, and Cooper 2000). Because increasing profits and cutting costs were the new driving forces for the money hungry corporations, less funding was made available for treatment, even though demand had increased (Fox, Lessler, and Cooper 2000).

Managed care soon became the dominant force in health care during the 1990s (Kee and Overstreet 2007). Some estimates state that 60% of the American population were covered by insurance schemes by the late 1990s (Kee and Overstreet 2007), while other estimates claim that number is closer up towards 75% (Keisler 2000). Meanwhile, 50 million Americans were members of Medicaid in the 1990s, and it was predicted that by 2010 more than 60% of those who were covered would also become members of a MC health plan (Kee and Overstreet 2007). In addition, roughly 84% of American Psychological Association (APA) members were members of a HMO or PPO during the late 90s (Murphy, DeBernardo, and Shoemaker 1998). However, that percentage is estimated to be even higher today (Cohen, Marecek, and Gillham 2006).

2.3 What is Managed Care?

Managed care is an insurance-based medical care system that strives to provide individualized, cost effective, and preventative services to its consumers (Pulleyblank-Coffey, Olson, and Sessions 2001). MC is comprised of a number of plans including HMOs (Health Maintenance Organization) and PPOs (Preferred Provider Organization) (Cohen, Marecek, and Gilham 2006). HMOs allow

consumers to choose their primary physician, however, the HMO provider has the power to authorize treatment (Fabius 1997). Under this type of plan, it is not uncommon for the HMO provider to limit authorization due to the temptation of financial incentive (Cohen, Marecek, and Gilham 2006). The PPO plan on the other hand allows their consumers to choose a provider from an in-network list of professionals (Cohen, Marecek, and Gilham 2006), however, the professionals who opt to join this type of network must accept a reduction in fees as well as an increase in surveillance (Kent and Herson 2000). MC regulations and practices are uniform across all corporations despite their differing business models, and MC corporations prefer providers to use behavioral descriptions of symptoms, psychotropic medication, and directive, short-term interventions (Cushman and Gilford 2000). This treatment formulation is determined by the MCO's cost-benefit analyses, cost-cutting regulations, and their desire to increase profits (Cushman and Gilford 2000).

2.4 Managed Care in Theory and Practice

The road to psychological treatment requires both flexibility and patience. Indeed, most individuals who seek psychotherapy are first referred to their family doctor where they are prescribed a psychotropic medication, this is referred to as the "gatekeeper approach" (Metzl 1998). If this method fails, the patient is then referred to a low-cost provider for psychotherapy where the utilization management process begins (Welch 1994). Utilization management is a method MCOs use to manage healthcare costs through the use of case assessments (Metzl 1998):

> Under a system of utilization management, psychotherapists are required to call case managers after meeting with patients for the first time to present the relevant clinical information. Case managers plug this information into algorithms using decision tree, yes/no analyses. The purpose of such action is to determine the medical necessity of each case. The information is logged, a diagnosis is established, and if a case is deemed medically necessary, authorization is granted for treatment. (334)

Upon authorization, the case manager will approve treatment for a certain number of sessions, and will continue to monitor the treatment after each session (Metzl 1998). Monitoring methods include written reports from the psychotherapist, reading the client's chart, or sitting in on treatment

sessions (Metzl 1998). Utilization management creates a new issue for clients: "persons who never see the client and who may or may not have any training in mental health treatment are deciding whether an insured person can access their benefits and if so whom they may consult, for how long, and what kind of treatment they may receive" (Edward 1999, 87). In addition, confidentiality cannot be assured, and corporation fluctuations, such as downsizing and buyouts, threaten the client-therapist relationship as they risk the transfer of the client to another mental health care provider (Edward 1999). The introduction of these gatekeepers, restricted access to providers, the infringement on client privacy, and undermining the client-therapist relationship all contribute to a decrease in effective treatment and an increase in under treatment (Wineburgh 1998).

Out of these practices rises the MCO economy of interaction (Metzl 1998). Indeed, when certain consumers are considered worthy of coverage and others are excluded from the market, a three-party interaction economy emerges. This new economy uses preselection to discover desirable patients and exclude those deemed invalid, and more often than not, the patients left on the outside are often those who need care the most (Metzl 1998). Studies have indicated that MCO economics raises concerns about access to and the quality of mental health care (Wineburgh 1998). These concerns are due to a phenomenon called "medical necessity" which requires individuals to "manifest severe psychophysiological symptoms to a dangerous or disabling degree" in order to be considered eligible for treatment (Bittner et al. 1999, 104). Besides this judgmental component medical necessity adds to the therapeutic process (Miller 1996), it also perpetuates a restriction of services, which implies that too much demand depletes resources (Metzl 1998). Psychotherapy then becomes a commodity that the MCO must control. If not, then psychotherapy "would be abused if made available to all who asked for it, a type of plastic surgery for the mind that would be the source of unending and implicitly frivolous use, ultimately resulting in the draining of profits" (Metzl 1998, 335). In order to ensure that this precious commodity is not wasted, MCOs lower the time and money they spend on mental health care treatment (Metzl 1998).

It is evident that in order to achieve its profit goals, the MCO must homogenize the delivery of mental health care by limiting the number of treatment sessions, restricting eligibility, and encouraging professionals to utilize predetermined treatment modalities (Polkinghorne 2001). These cost-containment practices limit the possibility of tailored mental health care (Wilcoxon,

Magnuson, and Norem 2008) because MCOs believe psychological illness can be quantified (Cushman and Gilford 2000). In turn, these quantifiable measures can be communicated to therapists and case managers "to determine the proper planning and administrations of treatment techniques that are to be applied to the particular diagnostic category" (Cushman and Gilford 2000, 987). Indeed, HMOs create standardized treatment protocols for certain diagnoses. According to Chambliss (2000), HMOs use cost-benefit analysis ratios to develop these protocols, and create a "one-size-fits-all" treatment plan including which treatment modality shall be used, the treatment setting, and the length of treatment (Chambliss 2000). Furthermore, if MCOs find that a certain diagnosis results in a lower cost-benefit value, it is not uncommon for the MCO to reject fee-reimbursement requests for said diagnosis (Wilcoxon, Magnuson, and Norem 2008). These practices in turn create a certain truth for the MCO: the outcome of the clinical interaction can be predetermined (Metzl 1998). According to Cushman and Gilford (2000), if the therapist uses a predetermined technique for a predetermined period of time, then a predetermined result can be achieved. This is of course if the client is cooperative. Clients who are labeled as "difficult to treat" or "resistant" are considered problematic by MCOs. However, MCOs have a way to manage unruly subscribers. MCOs encourage their therapists to use the cognitive-behavioral modality, because according to Tompkins (1997, 50), this type of case formulation is "particularly helpful in ensuring that the patient complies with treatment recommendations, homework assignments, and other aspects of therapy that increase the likelihood of a positive outcome."

Clients however, are not the only ones who are expected to comply with the MCO's procedures and regulations; therapists must also become compliant as differences in interventions between therapists are not considered cost-effective (Cushman and Gilford 2000). According to Pigott (1997, 247), "variance in clinical practice results in widely varying types and costs of care, as well as clinical outcomes, for patients with similar conditions." It becomes clear that there is no room for the mental health practitioner's opinion on treatment, modality, or duration in the MMHC system (Cushman and Gilford 2000). The mathematical approach to treatment MCOs use to understand human distress translates to corporate overheads monitoring the therapist (Cushman and Gilford 2000). Therapist variance, in the eyes of the MCO, must be minimized, thus the uniform therapist is created. Indeed, "Managed care companies are looking for providers who are committed to goal oriented therapy. Preferred providers are selected based on a demonstrated

ability to diagnose a problem and return the patient to a functional level … [and] who understand that insight alone does not equal outcome" (Woods and Cagney 1993, 38-39).

Consequently, managed care in practice tends to value the interest of the company ahead of the client and the therapist (Miller 1996). Furthermore, managed care devalues the client-therapist relationship through the application of authorization techniques and outcomes research (Metzl 1998) Outcomes research in turn redefines mental illness, and lends power to the case managers who apply them (Metzl 1998). Case managers then use these findings to determine the average length of time needed to treat a particular diagnosis (Riffe 1998). Therefore, one must begin to question whether the use of outcomes research is to deny care instead of serving as a basis of provision (Metzl 1998). In addition, while there was an early hope that the introduction of utilization management and case reviews would decrease costs (Karon 1995), case management has instead eroded the therapist's decision making power, and ultimately, questioned their level of clinical expertise (Pulleyblank-Coffey, Olson, and Sessions 2001). Clinician efficiency and earning capabilities have been limited due to an increase in the non-reimbursable activities, such as paperwork and treatment approval telephone calls, MCOs require the professionals on their panels to complete (Murphy, DeBernardo, and Shoemaker 1998). Overall, the MC philosophy perpetuates under-treatment (Miller 1996) because of their simplistic procedures that misinterpret psychological illness as "simple to understand, easily identified, and easily fixed (Cushman and Gilford 2000, 987), that many patients cannot be cured (Donovan, Steinberg, and Sabin 1994), and the impossible task of treating everyone (Miller 1996). Thus resulting in the interruption of treatment as a means to manage patient loads (Miller 1996).

It is important to keep in mind that MC's business design has little to do with the therapeutic goals of mental health care practitioners (Roback et al. 1999): the primary goal of managed care is not one of humanity but one of financial gains (Bittner et al. 1999). As a result, MCOs strive to maintain a certain level of profits (Miller 1996). Karon (1995) argues that the MCO's cost-saving methods impair the quality of care. In addition, Metzl (1998), states that MCO researchers have not provided any evidence that cutbacks are not dangerous. However, in order to compensate for an increase in expenses, an MCO is required to reduce their services from 2,596 hours of psychotherapy to 1,531 hours, a 41% reduction (Miller 1996). In addition, MCOs are short-term cost orientated: "The

decision makers are not interested in saving money over a 4-year period…. They are only interested in saving money over the next 12 months. Next year … the patient will be in someone else's managed care plan" (Karon 1995, 8). As a result, "Prevention efforts have been largely ignored by managed care. This is because cost saving through prevention is a long-term approach. It involves spending money now, with the expectation of saving money in the future" (Karon 1995, 5).

Roback et al. (1999, 10) states, "managed care is not short term treatment. It is minimal care, as short as the patient or the therapist will allow before they protest." Simply put, MCOs view psychotherapy as an expendable commodity (Roback et al. 1999) where cost dictates authorization rather than the client's needs (Pulleyblank-Coffey, Olson, and Sessions 2001). Indeed, the less money an insurance company spends on its clients, the more money stays. However, Scherl (1985, 3301) cleverly notes, "spending less is not worth much if it does not do much" (3301).

2.5 A Summary of Research: Experiences of Mental Health Practitioners with Managed Care in the US

Many mental health professionals have joined MC systems thinking that doing so would be the only way to get paid (Bittner et al. 1999). However, joining a MC panel leads to an increase in outside third party control through the use of precertification requirements, utilization reviews, session authorization, and pre-developed agendas (Phelps, Eisman, and Kohout 1998; Cushman and Gilford 2000; Sperry and Prosen 1998; Edward 1999). Furthermore, MCOs vary in the treatments they provide, their relationships with the providers, integrity, economy, and fees (Miller 1996). Large numbers of clinicians in previous studies have reported MHO's impact on both their practice and their clients (Danzinger and Reynolds-Welfel 2001; Murphy, DeBernardo and Shoemaker 1998), as well as their autonomy and morale (Lovell and Ehrlich 2000). In addition, they have experienced issues with joining a panel, lengthy precertification and screening requirements, terminating treatment prior to client readiness, incompetent employees given the power to make clinical decisions, slow response rates from case reviewers, an inadequate number of therapy sessions, obtaining authorization for longer treatment, pressure to diagnose quickly, using too much time advocating for their patients' care, reimbursement issues, and confidentiality concerns (Rothbaum et al. 1998; Lovell and Ehrlich 2000; Murphy, DeBernardo, and Shoemaker 1998; Bittner et al. 1999). Outright denial of services is also a force to be reckoned with as MCOs

view illnesses that require more complicated and lengthy treatment as too costly (Metzl 1998). Denial of services in the past has also been grounded on irrelevant criteria not related to the client's condition, and clinicians note that therapeutic progress is negatively impacted by these denials (Denkers and Clifford 1994).

Research has indicated that perhaps the most frustrating and challenging components of being a managed care psychotherapist is session authorization and confidentiality. As mentioned earlier, MCO contracts allow consumers 20 sessions of psychotherapy per year, however, MCOs often pressure their providers to treat their patients within six (Karon 1995). When a client's services are prematurely terminated, the client-therapist alliance is affected. According to Sperry and Prosen (1998, 59), "limiting treatment is experienced by some patients- especially those with serious chronic conditions- as actual forced abandonment, perhaps while therapeutic rapport is just being established. Therapy may be interrupted at critical times, with resultant worsening the patient's condition."

Requirements and limitations on treatment brings into question the expertise and judgement of the therapist in spite of their knowledge and credentials (Edward 1999). As a means to cope with early termination, the psychotherapist has the option to transfer their client to another mental healthcare provider, however, the issue with this option is that the level of trust that has been developed between client and therapist is called into question by the patient (Riffe 1998). As a result, the client may begin to wonder if their therapist is able to provide adequate care, or if their problems were too complicated for the therapist to work with (Edward 1999; Riffe 1998).

The session authorization process also requires the clinician to divulge confidential patient information to case managers who themselves, have very limited clinical training (Clemens et al. 2001). The information that is passed onto the case manager is then logged into the MCO's data system and tracked in order to maximize marketing, micromanage the clinicians, and create company policies (Bittner et al. 1999). While data is essential in creating, managing, and maintaining a MCO, the creation of electronic data exposes the client to unknown MCO employees having unlimited access to their files (Bittner et al. 1999). Upon learning about the MCO client information databanks and their open availability, patients become weary of disclosing personal

information with their therapists (Bittner et al. 1999). This lack of privacy affects clients and clinicians alike. Therapeutic patients require a certain level of privacy in order to disclose private information; without this guarantee, progression towards therapeutic relief is halted (Bittner et al. 1999). Clinicians on the other hand find themselves reluctant to include damaging information on a client's record out of fear of discovery (Cohen, Marecek, and Gillham 2006). However, the clinician is required "to describe a client's condition with sufficient urgency and gravity [so] that reimbursement for treatment [will] be authorized" (Cohen, Marecek, and Gillham 2006, 255). The clinician is then presented with an ethical dilemma while trying to find the right balance between obtaining authorization without committing insurance fraud (Cohen, Marecek, and Gillham 2006).

It is clear that the MCO's standard of care does not match the clinician's ideal of care; MC compromises the professional's standard by forcing the therapist to "focus on superficialities without addressing underlying problems," use interventions they believe are ineffective, and not authorizing treatment for certain conditions, all of which impair the client-therapist relationship and interfere with the conduct of therapy (Cohen, Marecek, and Gillham 2006, 253). As a means to cope, clinicians attempt to either shape managed care to fit their work (resistance), or shape their work to fit managed care (survival) (Kirschner and Lachicotte 2001). In Murphy, DeBernardo, and Shoemaker's (1998) study, 52% of the participants stated that they altered the organizational structure of their practice by moving from a solo to a larger practice, joining an integrated network, or hiring clerical and other professional staff. In addition, out of the 48% of those who stated that they did not alter the structure of their practice, 23% stated that they are considering doing so in the future (Murphy, DeBernardo and Shoemaker 1998).

Studies have also shown that psychotherapists engage in a number of tactics to curtail the session limitations put upon both them and their clients including: advocating for more benefits, allowing their clients to pay out of pocket, reducing their hourly fee, offering treatment pro bono, referring the patient to another provider, and stopping the clock (Murphy, DeBernardo, and Shoemaker 1998; Kirschner and Lachicotte 2001). Another tactical method clinicians use to accommodate to the MC system is giving patients more severe diagnoses in order to obtain more sessions with their clients (Kirschner and Lachicotte 2001). In fact, in Danzinger and Reynolds-Welfel's study (2001), 44% of their participants either had changed a patient's diagnosis or considered doing so in order

to obtain MCO reimbursement. Therapists do so because they believe that MCO regulations compromise the therapist-client alliance (Zuckerman 1989). Indeed, "… the relationship between patient and physician is a bond, and the managed care entity is a massive interference with that bond" (Roback et al. 1999, 7).

Overall, managed care has interfered with the way psychotherapists view their professional lives (Roback et al. 1999). According to Bittner et al. (1999, 100), "we are attempting to take a stand for what we feel are psychotherapeutic values … privacy, choice and tailoring therapy to the needs of the client."

2.6 Resistance
Numerous studies have found that many psychotherapists question whether the MCO's approach to mental health care is ethically sound (Wineburgh 1998; Bittner et. al. 1999; Roback et al. 1999; Edward 1999; Murphy, DeBernardo and Shoemaker 1998). According to Edward (1999, 101), professionals who experience the strain of their ethics "are unable to exercise … clinical knowledge and judgment, [and] … find it difficult to maintain the degree of therapeutic composure necessary to relate and listen to … patients optimally." This is especially true with the introduction of a third party into the therapy room. The addition of the MCO threatens a professional's ability to develop, understand, and utilize the therapeutic process, causing these skills to become obsolete (Zuckerman 1989). Furthermore, one study that measured clinicians' responses to the beginning of changes in the mental health care delivery system found that a majority of professionals argued that the new limitations of MC were "substantially dissonant with their sense of what is entailed by psychotherapeutic treatment" (Kirschner and Lachicotte 2001, 449).

With a growing proportion of unsatisfied mental health professionals emerged a new coping strategy: one of resistance. Resistant psychotherapists argue that the MCO limitations on the duration and frequency of treatment promotes a "fixing" mentality (Kirschner and Lachicotte 2001). In other words, MCOs see therapeutic treatment as a one-size-fits-all solution. As a way to fight against the medicalization of their practice, resistant professionals choose "to utilize diagnostic labels as little as possible, to wax ironic about there being one 'correct' understanding or interpretation of a client's difficulties, and to clear enough time to enable the 'whole person' to

emerge and grow in the context of a therapeutic relationship" (Kirschner and Lachicotte 2001, 450). Other professionals show their resistance by remaining committed to providing services to their clients even when those services are limited or denied by a MCO (Murphy, DeBernardo, and Shoemaker 1998). Indeed, this commitment is in part due the psychotherapist's sense of duty and advocacy for their clients (Murphy, DeBernardo, and Shoemaker 1998). Murphy, DeBernardo, and Shoemaker (1998) found that even when therapists were unsuccessful in advocating for their client's needs against a MCO, they utilized compromise instead to find an appropriate solution (i.e. offering discounted sessions).

Managed care raises a question of justice for both clients and professionals alike (Sperry and Prosen 1998). However, it is the responsibility of the mental health practitioner to take action (Lovell and Ehrlich 2000); psychotherapists must fight to ensure that patients have access to and receive quality care (Sederer and St. Clair 1989). Indeed, resistant psychotherapists argue, "until managed care reforms, it is our ethical codes which will provide us with a reasonable and judicious guide to carefully evaluate MCO determination about our patients' mental health services" (Wineburgh 1998, 436).

Chapter 3: Methodology

3.1 The Qualitative Paradigm

The purpose of qualitative research is to create a picture of social and individual circumstances through the words and descriptions of participants (Creswell 1994). In other words, qualitative research seeks to understand the world through the eyes of those being studied (Bryman 2012). In addition, the qualitative paradigm assumes that reality is subjective, interaction between researcher and what is researched is necessary, a certain degree of bias is to be expected, and phenomena are meant to be understood in their natural environment (Creswell 1994; Marshall and Rossman 2011). Because emphasis is placed on the natural environment, qualitative research is context bound and interpretive (Creswell 1994; Marshall and Rossman 2011). In return, this focus on context and interpretation reinforces the development of an emerging design, and an inductive logic ultimately prevails (Bryman 2012; Creswell 1994). This mutual relationship

between context and inductiveness allows informants, rather than the researcher, to construct the reality of the research and the phenomenon itself (Creswell 1994).

3.2 The Phenomenological Research Design

According to Giorgi and Giorgi (2008, 27) phenomenological research "aims to clarify situations lived through by persons in everyday life." As opposed to traditional scientific methods that utilize variable identification and control, phenomenology does not seek to define phenomena in the same manner; the individuals with first-hand experience and the context in which it occurs are emphasized, rather that the researcher's preconceptions (Giorgi and Giorgi 2008; Creswell 1994). In addition, phenomenologists call the everyday lived experience of an individual their "lifeworlds" (Giorgi and Giorgi 2008). These lifeworlds are based upon intention and consciousness rather than awareness (Giorgi and Giorgi 2008). However, how do individuals communicate these lifeworlds? According to Giorgi and Giorgi (2008) Husserl, the founding father of phenomenology, would say through 'careful description.' Therefore, the job of the phenomenological researcher is to tease out the lifeworlds of the individuals who are impacted by the phenomenon at hand. However, it is important that the researcher remains neutral in their analyses as preconceived notions and expectations take away from understanding the experience of the *individual*. (Creswell 1994).

A qualitative phenomenological research design was appropriate for the current study because the theory and variables associated with the outside third-party influencer are still largely unknown. According to Creswell (1994), qualitative research is appropriate when researchers know little about the phenomenon at hand and wish to explore its causal factors. Furthermore, the best way to comprehend the individual experience through the eyes of the participant is to utilize the phenomenological perspective (Bryman 2012). In order to understand the lived experiences of individuals, a small sample must be utilized, and the researcher must set aside her own experiences in order to allow the participants' to be revealed (Creswell 1994).

3.3 The Role of the Researcher

Unlike quantitative research, qualitative research entails a certain degree of researcher bias into the design, implementation, and review of the study (Creswell 1994; Bryman 2012; Smith and

Osborn 2008). Throughout this process, I may not have been immune to the introduction of my own biases into this research project.

I am a California native with first-hand experience within the managed health care system. In addition, I come from a family with a long history of mental illness, and while I have not personally been subjected to the ramifications of managed health care, I have family members who have. There is no question that these second hand accounts have altered and shaped my view of the American mental health care system.

On the other hand, I am an outsider and know little of the Norwegian health care system, besides the fact that Norway utilizes a successful socialized approach to health care that is copied and idolized the world over. Therefore, I expected the Norwegian mental health care system to nurture a more positive working environment than the one in the United States. As such, it is important to note that these biases may have caused me to judge the American system more harshly than the Norwegian during data collection and analysis.

3.4 Setting

The study was conducted in a number of different settings. Out of the eight interviews, three were conducted in the offices of the informants, one was conducted outside at a café, two were conducted over a skype video chat, and two were conducted in the interviewees' homes. The choice of setting was determined by the interviewee so as to allow them to be comfortable and encourage an open flow of conversation.

3.5 Informants

The informants selected in the United States were recruited in a number of different ways. Two of the informants were selected through word of mouth. I was familiar with other persons who knew the interviewees, and was put into contact with each respective informant. The other two interviewees were recruited through a university email system. After email correspondence explaining the parameters of the study, each "cold-call" individual agreed to be interviewed. The individual who I interviewed at the café was dropped from the study because the interviewee sent his research assistant to the interview instead. As a result, the delimitations of the study restricted

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this individual's ability to partake in an interview. The informants selected from Norway were all contacted through connections I had with professors at a Norwegian university. Some were contacted via telephone while others were emailed. Again, each interviewee was informed of the study prior to participation agreement. Pseudonyms have been assigned to all interviewees to insure their anonymity.

3.6 American Informants

James is a retired therapist who has been working in the field since 1976. He has extensive work experience within private agencies, governmental agencies, non-profits, and private practice. He has recently retired as the clinical director of a local chemical dependency recovery program.

Julie is a licensed marriage and family therapist, and has been practicing since 1996. Her background is within non-profit organizations and the MediCal system. Most recently she has been employed at an intensive outpatient hospital where she completes the assessments required for insurance approval. At the time of the interview, Julie was applying for insurance panels.

Paula is a psychologist and professor with a background working within community mental health centers and with Medicaid patients. More recently, she does clinical work in her own private part-time practice alongside her academic position. She is a member of one insurance panel and does not plan to apply for others in the future.

3.7 Norwegian Informants

Irene has been practicing clinical psychology since 1983. Her career started out working within adult and child psychiatry, and student counsel services. In 2000, she became a public psychologist and has between 20 and 30 hours of therapy work per week. Irene sees roughly 56 patients.

Marius has been working as a public psychologist for the previous 20 years. In the past, he has worked at the student health care services at a major university in Norway, at an adult psychiatric ward, a specialty school for the blind, and a children's psychiatric ward. For the past 15 years he has worked exclusively with adults.

Martine obtained her professional degree in psychology in 1976, and began developing psychotherapeutic methods for drug addicted clients and used them in her clinical setting. In addition, she also worked with HIV positive clients at this time. From 1990 to 2000 Martine worked in a private practice, and from 2000 until 2012 she worked at a behavioral center where she did clinical family work. More recently, she has started her own private practice where she treats only out-of-pocket patients.

Roar has been working clinically since 1984. He has always worked as a public psychologist, first starting out in the military. After his service as a military psychologist he began working at an acute psychiatric ward for drug addicts, and then with children. He later worked as the chief psychologist at a district psychiatric unit, and then as a family therapist for a family training program. For the past 13 years he has worked part-time at the clinic while studying for a Ph.D. At the time of the interview, Roar was not involved in clinical work, but worked full-time as a professor.

3.8 Ethical Considerations

According to Davies and Dodd (2002, 281) "ethics are an essential part of rigorous research". Furthermore, ethical research seeks to limit harm and respect participants (Marshall and Rossman 2011). However, interviews, as is the case in this study, require participants to share sensitive information, which is obtrusive in nature (Creswell 1994). As such, proper care must be taken in order to do no harm.

This study sought to ensure that the proper ethical standards were upheld, and that the integrity of each interviewee was respected. As such, prior to the outset of the study, I sought out the approval from the Norsk Senter for Forskningsdata or the Norwegian Center for Research Data (NSD). After submitting my application, my research was approved under the condition that I protect my informants through the use of informed consent. Interviewees were verbally informed about the objectives of my study and given the opportunity to agree to participation prior to the interview. While all contacted persons agreed to be interviewed, participation was voluntary, and

if one chose to decline either prior to or during the interview, the interviewee would not have been obligated to continue.

Indeed, due to the sensitive nature of the information that was shared and discussed throughout the interview process, great care was taken to ensure that said information was safeguarded and kept confidential. Both the recorded interviews and the transcriptions were kept within a password protected folder on my own personal computer, and were not shared with anyone other than myself. Furthermore, aliases were used in order to protect the identity of my informants, and they are referred to by these aliases both in the transcriptions and the research presented below. Data on their true identities was not recorded. Finally, all research material was used according to the original purposes that were approved by the NSD.

3.9 Strategies for Data Collection

Data was collected through a one-time interview with each interviewee located at a place that was suggested by and convenient for each of them. Interviews were semi-structured and lasted between 30 and 85 minutes. The interviews were designed this way to allow the interviewee the freedom to guide the interview (see Appendix A for a list of interview questions). Therefore, interview length was determined by the interviewees' responses and the natural flow of the conversation rather than a set length of time. The interviews were simultaneously recorded on an electronic PC voice recorder as well as a traditional hand-held voice recording device in order to ensure that any mechanical failures would not disrupt the data collection process. After the interviews were complete, I transcribed each, resulting in 112 pages of transcription.

3.10 Strategies for Data Analysis

Due to the qualitative nature of this study, data collection, interpretation, and analysis were conducted simultaneously throughout the research process. This was beneficial because according to Creswell (1994) conducting multiple components of research alongside data analysis is necessary as the researcher remains constantly engaged. Furthermore, when the researcher is engaged, she notices new themes and questions the participants raise, leading to research maturation which encourages inductive understanding during data analysis (Bryman 2012).

Because qualitative research analysis is eclectic and does not require researchers to bind themselves to a predetermined theory, the qualitative investigator seeks out patterns to guide the inductive interpretation of the data instead (Creswell 1994). According to Creswell (1994, 7), "…in a qualitative methodology inductive logic prevails. Categories emerge from informants rather than are identified a priori by the researcher. This emergence provides rich "context-bound" information leading to patterns or theories that help explain a phenomenon." In order to attain this context-bound information I utilized Thematic Analysis. I read through each individual transcript, first without notation, and then a second and a third time with notation, in order to reduce the mass quantity of information I had. I then used the interpretations I had developed after the reduction of the data to discover the patterns within each transcript. Now that patterns were in place, I was able to identify the themes that began to emerge using Ryan and Bernard's (2003) theme identification tactics: I made note of the repetitions (the keywords and themes that frequently occurred), the transitions (the shifts in conversation the interviewee made), the similarities and differences between interviews (how interviewees agreed or differed in their experiences), and linguistic connectors (phrases like "because", "since", and "as a result").

Upon the development of these patterns and themes, framework matrices were constructed to make orderly sense of the data. Each framework matrix allowed me to organize the data according to the themes and subthemes that emerged from the patterns (Bryman 2012). Care was taken to ensure that the information that was inserted into the matrix followed Ritchie, Spencer, and O'Connor's (2003) guidance: notation of the where the information came from within the transcript, maintenance of the informant's original language, limitation of direct quotes, and use of abbreviations when appropriate.

Once the data were coded, themes were discovered, and the information was organized, I used Interpretive Phenomenological Analysis (IPA) to analyze the data. The IPA analysis method was chosen because interviewees were given the freedom to talk about their own personal experiences, and as a result, the data analysis portion of this study must also reflect that. Smith and Osborn (2008, 53) suggest that when researchers use IPA, they should ask themselves during the analysis process, "what is the person trying to achieve here?" As a result, I kept this question in mind as I identified quotations within each transcript that coordinated with each theme.

Individual quotations grew to become collective groups of quotations. These groups were then analyzed in detail according to what the mental health care professionals said about each theme. This allowed each individual's own perception define the confines of my interpretation. The themes were then analyzed again to determine how each interviewee's account reflected their overall experience.

3.11 Verification

The accuracy of information in a qualitative design is often unquestioned (Creswell 1994). However, according to Creswell (1994), qualitative research can achieve internal validity through verification. Verification often involves triangulating the study's findings with different resources (Creswell 1994). In order to achieve this verification, the internal validity of this study was established through a combination of theory triangulation and the search for alternative explanations. Both are exemplified throughout this paper including the introduction, results, discussion, and conclusion sections. The external validity of this study is ensured through the application of a number of strategies. First and foremost, a high level of transparency is used through detailed descriptions of the study's focus, my role as the researcher, informant information, descriptions of the data collection and analysis process, and parameters of the study. In addition, the triangulation methods I have incorporated help to bolster the validity of my findings.

However, in spite of the internal and external validity that has been established, generalizability, and thus reliability, cannot be achieved. The uniqueness of this study makes it nearly impossible for the findings to be replicated uniformly in another setting. Indeed, this study's sample consisted of only three Americans and four Norwegians, and as such, the opinions and experiences of these seven do not constitute the experiences of the population. However, the inability to generalize the findings of my study does not devalue my work nor the experiences of the informants. According to Creswell (1994), the goal of qualitative research is not to generalize the outcomes of the study, but rather create new meaning. Surely another researcher in another point in time may be able to use the current study as a blueprint in guiding the central assumptions of their study in order to ascertain the unique experiences of other psychotherapists.

In return, this future researcher can use these unique meanings to contribute to the ever growing understanding of the outside third-party phenomenon.

3.12 Reporting the Findings

According to Bryman (2012) methods for qualitative reporting are not abundantly clear. However, according to Palinkas (2014) the phenomenological perspective requires the researcher to adopt a holistic perspective and go beyond the themes in order to create a larger picture of the phenomenon. As such, this requires the researcher to "provide a more comprehensive understanding of [the] meaning, operation and relationships" of the theories that emerged (Palinkas 2014, 857). Taking this into mind, a descriptive narrative proved to be the best method to report this study's findings. The descriptive narrative allows the portraits of the interviewees to remain intact without the interference of my own interpretations skewing the results. In order to uphold the integrity of the interviewee's voices, I have incorporated direct quotations from the interviews so as to create a unique narrative and not a scientific report. Each narrative generates a thick phenomenological description of the interviewees' collective knowledge regarding third-party influencers.

Chapter 4: Theoretical Perspective

Contrary to the a priori nature of qualitative phenomenological studies, where theory emerges from the design (Creswell 1994), one of the requirements of this project was to identify guiding theoretical perspectives. As such, the theories I chose were Organization Theory, Evidence-Based Management Theory (EBT), and New Public Management (NPM). They will be reviewed here.

4.1 Organization Theory

Organization Theory emerged in the 1930s as a by-product of the American industrial revolution (Shafritz, Ott, and Jang 2011). Classical Organization Theory subscribed to certain fundamental ideas including (a) the purpose of an organization is to achieve production and economic goals, and (b) the most effective way to organize production is through scientific study (Shafritz, Ott, and Jang 2011). Furthermore, according to Shafritz, Ott and Jang (2011, 33) under this classical school of thought, organizations "should work like machines, using people, capital, and machines as their parts." In turn, this mechanical and automatic philosophy encourages the idea that if there is a right

way for a task to be best achieved then there is also a right way for the social organization of the firm to be achieved (Shafritz, Ott, and Jang 2011). As a result, "such principles of social organization [are] assumed to exist and to be waiting to be discovered through diligent scientific observation and analysis" (Shafritz, Ott, and Jang 2011, 35). However, the end of World War II ushered in a new means for explaining organization. As opposed to the classical theoretical viewpoint, Neoclassical Organizational Theory stressed the need for cooperation between administrators and included sociological concepts. Indeed, "one of the major themes of the neoclassical organization theorists was that organizations did not and could not exist as self-contained islands isolated from their environments" (Shafritz, Ott, and Jang 2011, 93).

These two theories laid the groundwork for more theoretical development in the coming decades after their inception. One such theory was the Human Resource Theory or the Organizational Behavior Perspective. According to Shafritz, Ott, and Jang (2011), this theory concludes that the main purpose of organizations is to serve the needs of their subscribers because both parties rely on each other in order to create new ideas, improve production, and increase economic power. Therefore, when the missions of the individual and the organization do not mesh with one another both parties will suffer as either the "individuals will be exploited, or will seek to exploit the organization" (Shafritz, Ott, and Jang 2011, 150). As a result, it is imperative that both the individual and the organization work in tandem in order to ensure a codependent relationship instead of dependence (Shafritz, Ott, and Jang 2011). Organizations that prescribe to this theory value the individual human and are transparent in their actions, and, as a result, provide their employees "with information they need to make informed decisions with free will about their future" (Shafritz, Ott, and Jang 2011, 149).

On the other hand, Modern Structural Organization Theory assumes that organizations are rational, and require defined rules and authority to achieve established goals (Shafritz, Ott, and Jang 2011). As a result, control is highly valued, and labor specialization is viewed as a necessary tool in order to achieve production quality (Shafritz, Ott, and Jang 2011). Overall, the main objectives of this organization is to be efficient, rational, and increase production. In turn, these objectives create a mechanical process where hierarchies, rules and regulations, and top-down communications are

used to manage the firm (Shafritz, Ott, and Jang 2011). In addition, when problems emerge, they are attributed to structural flaws within these mechanical processes (Shafritz, Ott, and Jang 2011).

4.2 Evidence-Based Management Theory and New Public Management

Evidence-Based Management Theory contends that health practitioners must base their interventions on methods that have been shown to be most effective in clinical research trials in order to reduce the underuse, overuse, and misuse of certain treatments (Walshe and Rundall 2001). Furthermore, underuse, overuse, and misuse drive "the way that health care organizations are managed and health services are delivered" (Walshe and Rundall 2001, 437). Indeed, the overreaching goal of EBT is to discover a specific treatment that "alters the natural history of the disease for the better" (Cochrane 1972, 20).

In order to seal the gap between research and treatment, and achieve this overreaching goal, major reforms of health care management involving the researcher, practitioner, and organization are required (Walshe and Rundall 2001). According to the EBT paradigm, research must involve national level coordination, be linked to health service needs, and consist of larger research projects that lead to changes in clinical practice. (Walshe and Rundall 2001). In addition, practitioners are to be informed of the research and be active in applying the results in their own practice, and the organization must invest in the research findings, through the utilization of oversight, in order to encourage implementation (Walshe and Rundall 2001). In turn, this new triad of management will create a superior connection between practice, policy, and research (Boruch, Petrosino, and Chalmers 1999), and encourage new practice methods (Walshe and Ham 1997). Therefore, management through evidence is extraordinarily necessary. Indeed, according to Cochrane (1972), the oldest and most common form of evidence in clinical practice is the clinical opinion, however, this type of evidence is flawed due to the differences in values, abilities, and experiences that vary from clinician to clinician. Furthermore, when treatment is assessed, the biases of the clinician becomes an additional variable in the assessment, thus, clinical opinion is "the simplest (and worst) type of observational evidence" (Cochrane 1972, 20).

Similarly, New Public Management determines organization efficiency through the use of evidence-based methods, including performance indicators (Schachter 1989). Simon (1976)

reiterates this ideal when he says that the administration of the organization must be based upon scientific observation. Furthermore, the evidence-based methods NPM utilizes in order to obtain organization efficiency includes budget cuts, performance accountability and auditing, privatization, decentralization, strategic planning, competition, performance measurement, freedom to manage, and separation of politics and administration (Gruening 2001). In addition, managers are expected to plan, organize, direct, coordinate, report and budget (Gruening 2001). Thus, organization management becomes mechanical. This is reflected by the rational approach of NPM and its emphasis on "the gathering and analysis of information in the search for optimal answers to management problems" (Gruening 2001, 11).

Overall, EBT seeks to adopt uniform treatment standards through the use of planned and rational performance measures (Walshe and Rundall 2001). In addition, due to the clinician differences, EBT is the most effective and non-biased way to seek and discover the most effective treatment. Similar to EBT, NPM also utilizes evidence-based methods. However, NPM seeks to solve administrative problems and ensure the efficiency of the organization (Gruening 2001) rather than treatment.

Chapter 5: Results

5.1 The American Psychotherapist Experience

5.1a Joining a Managed Care Panel and Maintaining Membership
James: "most of the time they're looking for people." Paula: "I got approved very fast." Julie: "I hear it takes a year to get on some insurance panels."

The American interviewees in this study had mixed experiences when it came to the process of becoming a managed care provider. However, the consensus among them was that it was generally simple due to the lack of providers. James said, "most of the time they're looking for people…. because there is, and especially now, there's way more clients now that are eligible for services so there's really a shortage for therapists…." Paula experienced this phenomenon and found the process of becoming a managed care provider simple when she first joined, "it was very easy I

filled out the application online I gave them my CV and you know all the information they needed and I got approved very fast."

In spite of the apparent need for therapists and the ease of applying for membership, Paula offered some insight as to why it was perhaps easier for her than it has been for others in the past, "well what happened this time around was … someone told me that the panel was open… I went there to the website and … so I filled out the application immediately and I got in, but you know … I would imagine that they were interested because I am fully bilingual and they don't have a lot of people who are…." From Paula's account it seems as if MCOs cherry pick their applicants, especially when the person applying has a set of skills the MCOs are looking for. Others in fact, have not experienced this ease; Julie mentioned that she hears "…it takes a year to get on some insurance panels…."

Applying for and becoming an approved provider however, is not the end all in becoming a managed care practitioner. In order to maintain membership, one must jump through certain hoops. In fact, James described his experience with maintaining his membership through the requalification process he endures regularly:

> "… every licensed person has to re-up their license … on a regular basis…. I have to do it every two years. By it I mean I have to do a certain number of CEUs, take a certain number of classes, I might have to take a test, written, and pay my fee to do it okay? But with managed care for example they require all that same stuff plus they sometimes give you little vignettes; in this kind of a situation how would you handle it and why would you handle it like that?"

So while the process of becoming a member involves a certain degree of effort, maintaining membership also involves conscious labor on behalf of the therapist in order to prove that he is still worthy of calling himself a MCO provider. According to the interviewees, the apparent simplicity of applying and becoming a provider that MCOs advertise to clinicians may not be so simple in practice. On one hand, MCOs have an influx of clients, and not enough therapists to care for them. However, this seems to be colored by a certain type of client, and therefore the need for a certain

type of provider. As a result, those clinicians who can adequately provide that specific level of care appear to be given precedence.

So what kind do practitioners not falling within the MCO need category experience? Julie offers some insight: "… I'm not any insurance panels, and people I know at work who are therapists part time in the program … they've approached me and said "I'm full can you take clients?" and I've said "yeah, but I don't take any insurance" and they're like "oh okay never mind," so people who take insurance seem to have plenty of clients because there's people out there that need to use their insurance, [and] do use their insurance…." What are practitioners like Julie to do?

5.1b Combination of Income Sources

James: "…it is a combination of managed care folks as well as individual pay that constitutes a good practice…"; Paula: "… if you want [a] private practice that will give you a happy income you have to work with insurance companies"

A common method for MCO and non-MCO therapists alike is to seek out other sources of income. In fact, all American psychotherapists in this study reported that they are compelled to supplement their work as a managed care mental health care provider with other sources of income. James said that he did so because:

> ... the managed care … companies are paying considerably less than … the normal fee.… When I worked at [place] I got paid forty-nine dollars an hour, [but,] …my … run of the mill client, I would charge them seventy-five and they would pay seventy-five…. I would get referrals [from MC], so five, six, seven referrals in a week, and I could see them. So I would be making let's say about fifty dollars a session for [MC clients] in a week, and I might only have seven, six of my own clients…. I would say that I think it is a combination of managed care folks as well as individual pay that constitutes a good practice….

Furthermore, due to the regulations set forth by MCOs, James mentioned "there are some managed care programs [where] … I can't charge you more so it's either take the … payment or don't see that person…." He said as a result, "I managed my own practice; some managed care, some private

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pay, some EAP panels … and … custody evaluations for family court, … so I had a variety of income sources so I could stay in private practice and in my own company." Paula also mentioned her concern about her earning power as a MC practitioner, "It's not a hobby. It's not that I don't need the money, of course I need the money. I have job security … at the [university] so I'm not worried about how many clients I get in a week, … and that's good. I always have clients, but that's not the same when you have to rely on that to pay your expenses. That's a whole different thing."

Still, not every therapist chooses to work within the managed mental health care scheme. James discussed his knowledge of therapists who do not subscribe to insurance panels, and offered a reason for why they do not do so. James said, "I know therapists who didn't do any sort of managed care they just did all the other options, and some of them might have started out doing some managed care to kind of get their practice going, but then their practice got really going so that they could not do these things for the reasons we talked about, they pay less, [and] there's a lot of paperwork…."

Due to this low pay and high demand, therapists appear to be compelled to seek out other incomes. The incorporation of multiple income sources allowed the therapists in this study to limit their reliance on MC. Indeed, when Paula was asked about these specifics, we had the following conversation:

> Me: so it sounds like your strategy is to limit yourself….?
> Paula: Yes, and I can do that because I have the security of my job as a professor
> Me: Do you think if you didn't have a teaching position that it would be different?
> Paula: Yeah it would be very different. I think private practice has ups and downs, sometimes it's full sometimes it's not so full; it's not financially stable always and … if you want [a] private practice that will give you a happy income you have to work with insurance companies because most people, unless you're catering to the wealthy wealthy who can pay 200 dollars an hour every week, … [they] want to use their insurance….

Still, Paula limits herself in other ways, she said "I basically work with the insurance that I know through my peers that are the best to work with in terms of reimbursement and easiness." She tells

of choosing to supplement her work as a managed care practitioner because, "... I wouldn't want my whole business … with insurance that would be only crazy for me [because of] … the paperwork, because of the limitations…." Mental health practitioners appear to be well aware of the high demand that is required of them and the little choice that they have when they work under the MCO umbrella.

Overall, American psychotherapists suggest a sense of obligation to seek out multiple sources of income when they become managed mental health care practitioners. The interviewees in this study believed this to be true due to the limited compensation and high demand associated with MCOs. In addition, choosing a combination of sources gave them a sense of power and autonomy by allowing them to control their reliance on managed care referrals, rather than the MCO.

5.1c Adjustments in their Practice

James: "… it wasn't enough for me to have the training, I had to be able to prove that my treatment plan matched and fit…."; Julie: "the medical model rules"; Paula: "you just give them what they want"; "… they really shape the way people practice…."

The new rules and regulations the introduction of managed care brought along with its inception has required American mental health practitioners to adjust their practices accordingly. James mentioned "… I had to be more mindful of the timeframes, the documentation processes and, and substantiation of why I was doing what I was doing…. Before that there was kind of like "well you know best, so you know what you're doing, that's why you're licensed…." Well, it wasn't just enough for me to have the training I had to be able to prove that my treatment plan matched and fit with a diagnosis…."

This requirement of therapists to be more mindful of the time they spent with their clients, and the time they needed to set aside to document treatment and review their charts meant that psychotherapists were required to do extra work. However, this new workload meant that therapists could not spend as much time with their clients as they did before. According to James, "…instead of a sixty-minute session you might have a fifty-minute session with ten minutes for documentation, so that's where … the practice of what they call a fifty-minute hour came from;

you bill for sixty minutes even though your face-to-face was only fifty minutes because there was an understanding … that they require you to do documentation." Paula further describes her experiences at the community clinic, "centers … and their funders drive … in a very powerful way how treatment is provided and what amount…. For example, when I started working in that clinic in the 1990s family therapy was 90 minutes, then it changed to 50 minutes just because they wanted to cut it, and nowadays it's hard to find anybody who works more than an hour whether it is individual, family or couple therapy because they have shaped the practice…."

Julie offered an explanation for the adjustments her and other practitioners are required to make when she said "the medical model rules," and, "that's why we are trained to be really careful about finding medical necessity…." For Paula, adjusting to the medical model meant that she had to utilize other forms of therapy: "… they want what they call evidence-based treatment, which is pretty much cognitive behavioral therapy or the like…. They really shape the way people practice because the way you write your notes and what treatment plan, it's pretty much a behavioral plan and they want you to operationalize this and that and create goals that are measurable. And it becomes a game of language where you have to put … what they want…."

However, Paula argued that adjusting to MCO regulations is robotic at best, "it is so mindless…. There are books that are called 'the family therapy treatment plan' or the 'individual treatment plan', so all you have to do is get one of those books. It basically gives you the DSM diagnosis, the symptoms, the short term goals, and the long term goals…. It's a formula. It becomes writing in a formula, so you just do that. You just give them what they want."

Despite the MCO dictation of how therapists should spend their time and what type of treatment they should utilize, psychotherapists still try to adjust their practices in a way that favors the benefit of their client. For James that meant incorporating a sliding fee scale for those who could no longer afford treatment; For Paula this meant that, "… I had to find a way in which … to navigate the systems so that I could do the work that I was prepared to do, and was the best I could offer. Sometimes … with family therapy I ended up giving up some of my time when they had hour, and with couple therapy … it was the same. So I ended up not being paid for all the work I was doing, but it was most important to do the work…."

While it is important for the therapist to do everything in his or her power to ensure that MCO regulations do not negatively impact the client, Paula says that the tactics her and other psychotherapists employ, including sliding fees and pro-bono work, are "not sustainable in the long term."

5.1d Qualifying Clients

Julie: "people that give me benefits don't have [clinical training] … their job is to not spend money…"; James: "… the bad experience would be when someone I think is in need but doesn't qualify." Paula: "We only gave certain diagnoses… that we knew were going to be covered."

Qualifying clients has been a steady issue amongst psychotherapists since the inception of managed care. James mentioned, "I think initially there was a problem because there was a lot of confusion and there was a lot of adjustment for everyone… and so people would be getting misinformation fairly often in the beginning…." This confusion and misinformation often meant that people who were initially qualified in fact were not and as a result, according to James' account: "we would get the message "oh no, they're not eligible so don't see them anymore."

And so began the introduction of qualification. Today, as James put it, the MC qualification process has evolved into qualifying "the person for the level and kind of services that they are eligible for" and "then they qualify the providers to provide… that level of service and varieties of service and then they match them up." Moreover, James reported that the client "would call a certain central number, they would … do an evaluation and you would be sent to a provider who provided that level of service." According to Julie however, "people that give me benefits don't have [clinical training] … their job is to not spend money if you know what I mean." In other words, the MCO's desire to cut expenses determines how much money they invest in their subscriber's treatment, the duration of the treatment, and what kind of services are provided. For James this was typically 16 sessions per year, however, "if there were reasons why the therapist thought that the person needed more than sixteen sessions in a year then we would have to … be able to justify more than that number of sessions." It becomes clear that the power to determine qualification no longer lies within the hands of the mental health practitioner.

There are instances however when qualifying a client is less difficult. Julie says, "if a … licensed person feels the person is a danger to themselves or gravely disabled my experience is that the insurance companies never challenge that … you're going to get the initial authorization." Furthermore, Julie has also found that qualifying clients who are "stepping down" is easier than obtaining authorization for your run-of-the-mill client, "it's easy to get [qualified]… especially if somebody has been inpatient hospitalized. The insurance company calls it stepping down. So if somebody is coming from inpatient it is highly unlikely that they're going to not authorize [treatment]. What they'll do is step them down from inpatient to … intensive outpatient…. I've never had … an insurance company say 'no we don't think that level of care is needed' they're always like "yep that sounds good to us.'"

This form of regulation allows managed care to use qualification as a gatekeeping process, becoming essentially, what James called, "the person who says yes." James also mentioned "… the bad experience would be when someone I think is in need but doesn't qualify…. In order … to come to me you need to go through this process to get qualified as … a managed care patient. So [w]hen the person…get[s] denied for who knows what reasons … [it means] that person has to pay out of pocket." As a result of these gatekeeping tactics, the insurance company often appears to have more control over the client than the practitioner does herself. When Julie was asked this question she said "that's right." She also mentioned that this type of leverage the insurance company exerts over the therapist is contrary to the philosophy of treatment:

> we sit with people, we sit in their presence, we're emotionally resonating, we're attuning with that person face to face, we gather seven pages of information that's anywhere from an hour and half to sometimes two hours … and we also … call a psychiatrist and the psychiatrist has to accept the patient before we move forward with authorization … so in my mind you've got a licensed marriage family therapist and a medical doctor saying this treatment is necessary and yet sometimes insurance companies say "nope we disagree." … They're listening to you talk about the patient but they have no contact with the patient.

Another method of gatekeeping MCOs use during the qualification process is medical necessity; according to Julie, "[the insurance company will] say "if [the patient doesn't] have high blood pressure, if there's nothing medically to supervise, we're not gonna authorize that level of care.'" Furthermore, Julie pointed out that the insurance companies use medical necessity to monitor their clients not only during the qualification phase but throughout the entire therapeutic process: "What they say is that this is covered based on medical necessity, and later if you can't show medical necessity the person ends up with a bill rather than the insurance covering it. So just because they start the program doesn't mean that down the road somebody at an insurance company when they review the case is not going to go "wait, … we don't think you needed this anymore so we're not going to pay for these days", it happens all the time." Indeed, the qualification process appears to be a never ending process. Julie explains further:

> …they do an initial authorization… they'll say "okay, we'll authorize ten days… at the end of ten days we have a therapist who's a utilization review person that's all her job is, is to call the insurance companies and do a review … she just updates the insurance company so if they think at that point the person is medically is still necessary they'll authorize maybe another ten days … and then if you want longer time you have to talk to the insurance company again and at any point where there is reauthorization needed they can say "… we think this person is ready to go" and that happens all the time…. I have contact with her every day and she's like "yeah well the insurance company just said 'no they don't need treatment'" …. They have a lot of power and control.

James also described situations where a client's earlier qualification can be rebuked:

> … the eligibility for MediCal for example is, I guess you can say re-substantiated every month for a client. So let's say you were a MediCal client and then your uncle or somebody dies and left you some money. If it is over a certain amount of money you are not eligible for … MediCal … until you have depleted that to a certain amount … whether it takes a year or five years or three months or two months or whatever it takes you're not eligible. Then you have to reestablish your eligibility and so … it can be a hassle.

When clients cannot obtain treatment, a dilemma develops for the therapist. This appears to be true when the therapist herself believes that the client needs treatment. Julie said, "… sometimes we think that the person needs you know another two weeks … and the insurance company says "no, Friday is the last day that you can have them" so I know things like that happen where the insurance company, for whatever reason, they believe … it's not medically necessary past a certain time." This blatant disregard for the expert's opinion suggests that the therapist's voice appears to be unimportant to insurance providers as to whether or not clients qualify for care.

James sums up his experiences with insurance companies in this way: "all the companies want to reduce costs and make good use of the money." Julie adds further, "… there's a budget right? And the insurance company wants to make money…. They don't want to authorize everybody because that's going to mean more money out of their pocket. That means less benefit to them, so there's gotta be, you know, a balance."

In order to combat situations like these, Paula describes the methods she used during her time as a community provider in order to cope with MCO money saving schemes:

> when I worked in [place] … we had a criteria … in order for [care] to be covered…. We only gave certain diagnoses… that we knew were going to be covered, and the clinics I worked at they also knew…. You were told "don't ever give a personality disorder diagnosis because you can't get reimbursements for that." There are of course other reasons not to give that diagnosis but this was about money. It was like you know, you won't get reimbursed for that diagnosis, so don't give that…. At some point people start to learn what's accepted what's not and you just avoid what is going to bring a problem.

Julie also offers insight into coping with insurance practicalities when clients have duel diagnoses and limited coverage:

> I had a client that has struggled with addiction…. He came in, did an assessment. I called for his insurance benefits and found out that he had no, zippo, chemical dependency benefits. Nothing. And … his primary diagnosis was opioid dependence…. When I found

out he didn't have chemical dependence benefits I consulted with my colleague …and he said "yeah in cases like that Julie sometimes we bring the person back in to do a reassessment and we specifically look for and try to unearth mental health symptoms…." [But] it's hard sometimes to tease out whether…was he depressed and because he was depressed he started medicating and … instead of having depression now he's got depression plus addiction. Or did he have a pattern of addiction that led to psychiatric symptoms? … [so] I called him in to do a reassessment… [and] I specifically asked him about symptoms for depression. He had a lot of symptoms of depression…. According to [the client] he had called the insurance company and ... according to him the person that he talked to at the insurance company said "well you know if you can have … mental health benefits primary you can always come in that way and get help."

There appears to be a consensus among the psychotherapists that regardless of client need, it is the MCO ultimately deciding not only whether the client qualifies for care, but also what type of treatment and how long she will receive it. Julie lends her thoughts to this problematic situation by recalling, "sometimes … we recommend [a] higher level of care and when we go to get them authorized for that care the insurance company says "no, they don't meet criteria for that level of care" … or sometimes they've said "no, we don't think this person needs that kind of care at all," … so the voice of the insurance companies is definitely a force to be reckoned with."

One clear theme appears to take shape from the psychotherapists' accounts of qualifying their clients for care: it is the MCOs, not they, who dictate which clients are or are not qualified to receive treatment. Julie exemplifies this when she said, "that's sort of what it is somebody else is making medical decisions, you know? ... If somebody can't get authorized they can't get treatment…. It's all about the insurance…."

5.1e Advocating for Clients

Julie: "...once you know what the insurance company is requiring, you really do try to advocate on behalf of the client…"; James: "it's not very difficult to get … re-upped. The problem is when someone really needs it and they keep their appointments"; Paula: "… for me what matters most is to help the client and see what is in their best interest."

One shared concern among the American psychotherapists in this study appears to be how MCO rules and regulations greatly limits their client's care. In trying to deal with this, they told of different ways for performing advocacy on behalf of those coming to them for help. Julie pointed out why it was necessary for her to advocate on the behalf of her clients when she said, "… when you're in a mental health crisis … circumstances have brought you to … the bottom of the barrel. You really do need other people to advocate for you…." She added that if therapist's have knowledge about the MCO's operations they then are better able to advocate for their clients, "I don't want to say it's a game, but once you know what the insurance company is requiring you really do try to advocate on behalf of the client."

So, in what ways do these psychotherapists advocate for their clients? Julie mentioned, "…we call insurance companies on [the] client's behalf, … so many times people are just overwhelmed with trying to get out of bed and shower or just, you know, get out of the house because they're so anxious or so worried … so that's something that we offer as a way to support people who are … in a very vulnerable spot." And, in cases where the client cannot access care, she told that, "… we always refer if somebody says "this program doesn't work for me" or "I can't do this.'" Paula also mentioned ways in which she makes care available to those who are denied, she said, "I offer a free consultation first to see if it's a good fit [since] money is a big factor." Paula also mentioned, "I would rather charge you less out of pocket then go through all that, and I do that sometimes…. I also have lower rate[s] and I … do some pro-bono work…." Together, these psychotherapists tell of the roles they play in trying to sabotage efforts by MCOs doing their best to deny coverage to those defined as "less than ideal" clients. Rather than obediently accepting orders from the MCOs, the American psychotherapists interviewed still found ways to extend care to those in need.

Despite successes in circumventing MCO directives, James told of how advocating for clients still remains a difficult task: "I've had this happen, … a person was given sixteen sessions, they used four, they stopped coming. Then, maybe three or four months later, they want to come back so then all we have to do is re-up that authorization. They have to get a new one, but basically it's a continuation of a previous authorization, for them to continue to get their sessions. So it's not very

difficult to get that re-upped. The problem is when someone really needs it and they keep their appointments…."

Situations like these where advocating for those clients who cannot be "re-upped," or those who are denied care appears to be frustrating for Julie. This was evidenced when she said, "… they're listening to you talk about the patient but they have no contact with the patient, nothing." She went on to say, "I think the frustration when you do hit walls with trying to advocate for clients with services [is] because you're sitting there in an office, [case managers] haven't seen the client, [they] don't know anything about them. We're telling you these things and yet you're making a decision…." Despite these frustrations that accompany advocating for their client's right to care, Paula says that it is worth it in the long run because, "…for me what matters most is to help the client and see what is in their best interest. So there is always this issue that insurance companies and the benefit of the client don't always align. For me it is more important to work to the best interest of the client…."

All in all, American mental health care providers find themselves in limbo trying to keep their client's best interests in mind while conforming to the demands of the MCO. In order to cope, Paula said, "I needed to find a way to give something to the insurance company… and be able to do my work with the client…." This understanding of putting the needs of the client first leads to, according to James, the therapist's "… realization that you cannot be totally governed by clock", and ultimately, pressure from the MCO.

5.1f Working Around the Managed Health Care System
James: "I had a pretty generous sliding-fee scale…."; Paula: "I prefer to charge less than work with insurance companies."; Julie: "… there's certain things that I've learned that really beefs up the presentation of a case."

The outcome of the limited care experienced by their clients owing to non-qualification issues has encouraged mental health practitioners to develop ingenuous ways to work around the MCO's rules and regulations, and get their client the care that they believe they need and deserve. In Julie's case this often means:

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Many times I'll say to a client "do you know about the fifty-one-fifty process?" and they'll say yes and sometimes they've had bad experiences … so I try and talk to them a lot about it because if they've had an experience where it was kind of negative, I try to explain to them that it will be much easier for us to get you authorized for treatment if we put you on a fifty-one-fifty hold. So I kind of try to come at it as "you need this level of care, you know? This is the way to access it." … it's something we do because we find that insurance companies are more likely to authorize if somebody is on a hold.

Telling about patients who are not an immediate danger to themselves or others, Julie goes on to say, "… but sometimes people … want help voluntarily. They say "can't I just come into the hospital and get a bed?" and it's like no, inpatient hospitalization is very expensive and insurance companies they'll find anything to deny paying." The inherent concern here appears to be connected to how therapists go about helping these types of clients. In cases like these, methods for working around the system go beyond just taking advantage of the "on-hold" system. For the psychotherapists interviewed, this requires them to be knowledgeable as to what the MCO considers to be an ideal patient eligible to receive care. As Julie puts it:

… being insurance savvy and knowing the ins and outs of the insurance company's system helps a therapist when they're gathering information; to listen, to ask certain questions, to focus on certain symptoms that you know the insurance company is going to ask about. What I know now … is very different than what I knew when I first started the job, you know? I'm always asking about sleep patterns and eating, … so there's certain things that I've learned that really beefs up the presentation of a case.

Being insurance savvy appears to be beneficial for Julie when she must distinguish between parity and non-parity diagnoses. According to her, parity means that, "there's certain diagnoses that … the insurance company won't cover, like maybe they'll cover … major depressive disorder but they don't cover depression not otherwise specified…." As a result, if a client is diagnosed with depression not otherwise specified, then she would not be eligible for treatment according to her

insurance company. In these instances, Julie tells of how she goes about getting non-parity clients approved for treatment:

> … we always have a list of diagnoses and beside it, it says parity, non-parity, parity, non-parity. So if somebody has generalized anxiety disorder and major depressive disorder, major depressive disorder has parity, the insurance company will pay for that; generalized anxiety disorder is not parity, so if I'm choosing which one is going to be primary I'm going to use the one that's reimbursed rather than trying to convince them that, you know, this generalized anxiety disorder which they say they're not going to cover because it's not up to par…. There's definitely diagnoses that have parity and others that don't.

What do American psychotherapists do when their clients are too "healthy" for a fifty-one-fifty hold, and are not diagnosed with a parity disorder? How do these therapists still ensure that their clients get the help that they want and need? For these types of patients, James said:

> I would say "well listen, I can do a sliding scale fee but you have to pay on your own and I charge this much, and you have to pay each time, and you have to pay for missed appointments." You know, I have my own rules so that I could stay in business and people would know that up front before they even agreed to come to me for treatment; they would know what they're getting in for in terms of their financial obligations, and then their responsibilities and their understanding of what mine are….

As a result, sliding-fee scales ensure that care is affordable for those who cannot afford it. James exemplifies this when he said, "I had a pretty generous sliding-fee scale. This was back in the early 2000s … when the general therapists were charging sixty-five, seventy-five dollars a session, then I would do that sliding scale. I … made up my own scale under this amount of income … with this many people in the family…. The lowest I would charge was twenty dollars a session, so if they were motivated they would more than likely come."

On the other hand, Paula's method of working around insurance companies involves limiting herself, "I prefer to charge less than work with insurance companies, and … if I work with

insurance companies I work with ones that I heard are the best…." She mentioned that this is necessary because "… at some point people start to learn what's accepted, what's not, and you just avoid what is going to bring a problem…. If I can avoid it, I will avoid it beforehand…."

As evidenced by the narratives of these interviewees, working around the insurance company has become a key element in the work of American psychotherapists whether it involves becoming more insurance savvy and knowing the ins and outs of the corporation, incorporating sliding-fee scales in order to make care more affordable for non-qualified clients, or choosing to limit one's practice. Paula summarized this best by pointing out that "it becomes a game … you just give them what they want…."

5.2 The Norwegian Psychotherapist Experience

5.2a Governmental Control

Roar: "… those who work with patients are always under some kind of surveillance…." Marius: "…they want everybody to upgrade themselves and they're checking if you do…" Irene: "…they demand more and more…" Martine: "… I … don't have any impositions or restrictions"

In a number of ways, the experiences of the American psychotherapists with MCOs appear to be mirrored in the accounts provided by the Norwegian psychotherapists about their experiences with the government and its control over their practices. As Roar put it in describing the government, "it's elitist and always governed from the top and few possibilities too. It means that those who work with patients are always under some kind of surveillance from people above." However, Martine remembers a time when the governmental system did not interact with therapists in the elitist way Roar described. She recalls during the 1990s that there were "no guidelines about treatment methods or diagnosing…."

Martine, however, does not experience the elitist governmental power. In fact, her work situation appears to be more special than the other psychotherapists interviewed during this study. Martine works as a private practitioner, meaning that she is not connected to the public mental health care system. As a result, she designs and maintains her practice according to her own desires, and the

governmental control other psychotherapists report experiencing appears to not be shared by her. She reported that "… now I don't have public support but I also don't have any impositions or restrictions other than the ones I have as a health care provider, but nothing more than that." She did however mention that the Norwegian Health Department (Helsetilsynet), "… can come in and ask to see the journals and accounting information, so there is a little public responsibility that I can be subjected to, but they don't come often, and they haven't done it so it's something I haven't experienced yet, but in principle I know that there can be a control." She went on to mention, "… we have colleagues [who] have been checked. I think that it can happen if there [are] problems with accounting or … something that causes you to be noticed or if you've gotten a compliant. The patient can also complain about health personnel so that would probably increase the chance that you will be investigated if there is something that caused you to be noticed, but it can happen randomly too."

However, in general, Martine has complete freedom over her practice. When asked about her experience with outside actors requiring her to work a certain way she said, "I don't experience that myself because there is no one who comes and regulates me, but I talk with colleagues …. I hear them describe that there has been more regulating than there was during the 90s, so I have reason to believe it even though I have not experienced it myself." Overall, because Martine does not receive public support from the government, the government cannot restrict her practice.

However, her experiences contrast greatly with those of the publicly employed psychotherapists interviewed during this study. When asked if he has experienced increased interference in his practice from the Norwegian government over the years, Marius said, "oh it's more, yeah, definitely more…. [They want] to see that we are working hard and we are working with the right patients.… Maybe they will have a look into … how much we are paid, … where we're working, … when and how we should work and … if we are also keeping our words, they never did that in the beginning." Marius also told of how the Norwegian government controls where psychotherapists work, "… there's a certain amount of clinical psychologists in town, and the government would like to … spread us out across the country so everybody has an equal chance to meet a psychologist if that's what is really necessary…."

Marius went into further detail about the governmental control he personally experiences in telling that "every fifth year you have to tell what kind of supervision and courses [you] have been taking … because they want everybody to upgrade themselves and they're checking if you do or if you don't, and if you don't they can say you are not following up your knowledge so you have to quit…" In addition, Marius reported about being told by the Norwegian government that he is required to care for a minimum of forty patients per year, with "some coming weekly some coming once a month."

Irene also discussed how governmental control impacts her professionally, more specifically, in relation to the prioritization of her clients and how the government's desire does not fit her practice modus:

> [there are] guidelines for who [has] the right to have help, and how long they are going to wait before they can start in treatment.… Now it [has] become so that [the government] demands more and more, that we should be in line with the rest of the health care system and prioritize [patients] the same way. For example, … when we get a referral from the doctor or the district psychiatric clinic, we have to do the evaluation quickly and say how long the waiting period will be, or that we can't take them. We have to prioritize in a way the sickest, but this isn't a service meant only for [them] because if you cannot come to the regular hours, if you're not able to keep the time, it's very hard to have patients here [like that] …. We have organized ourselves so we have one hour and one hour so if somebody is really ill and you have to use two or three hours on them to stabilize them and other things, they are not so fitted for this kind of practice.

Roar, too, also described his experience with governmental control through the use of standardized treatment, "… now you have these standardized packages that the Norwegian government will implement. Standardized packages [are] the dream." When I asked Roar what standardized packages are, he said, "we don't really know, but it has certainly a flavor of using evidence-based methods. They say that the methods you use or the way you work should be scientifically approved." Irene gave us more insight into what these standardized packages look like when she said, "we have to have of course name and addresses and identification number, … and then you

have to have diagnosis, and you have to have a plan for the therapy, an evaluation of that of course, and then something about the present situation for each hour and how it's going according to plan." She also mentioned, "… they want to decide who we are going to take, how long we are going to take them and … of course report or write down what we have done…."

There was some question from Roar about how beneficial creating and implementing standardized treatment truly is, "I worked with was drug addicts. They said it wasn't possible, just bullshit, but it's really possible to work with drug addicts, and there were young boys of the age 14 and 15 with behavioral problems [who were] supposed to be unmotivated, that was also bullshit. Now I've been working with families who are supposed to be difficult to collaborate with. These clients became difficult because you wanted them to confirm to the set of therapeutic rules."

With the Norwegian government becoming more hands on, Irene offered insight into why they have begun to be more involved in their work, she said, "… they wanted to have a sort of coordination…. I think it was, in a way, [a] government need to get an overview of the costs … so I think that was part of it. It was an [economic] reason actually, but there was also this wish to try and get the patients the best help." In spite of certain pessimisms, there still seems to be an understanding of why the government has become a greater influence within the therapy room, and an acceptance of their new role. However, concern still lingers. Roar described an encounter he had with a group of psychology students:

> I was teaching at the university and there was this group … and I said to them I really thought there was very little critique of the system…. One of the girls said … when we do work as psychologists, we do not have a permanent position, they are only … substitutes, so if you protest they won't hire you again. So I think that … it has to do with an economic system. The demand of being a flexible worker is also hitting our group, and you have to fit the system.

Overall, Roar argued that, "…the basic issue … is the constraints that our government puts on us and … people who develop a cultural fear, live in a culture of fear…. There's a lot of mixed

methods from our government…." Marius summarized it best when he said, "…that's the difficult thing; you have to know who are you working for or with…"

5.2b New Governmental Rules

Roar: "There's a pressure for assessment…"; Marius: "…things are very different…" "… the good thing is that … it's up to us how to organize our practice." Irene: "…if all of a sudden you get too tired or a lot of problems at work, you can … get helped."

According to Marius, "… things are very different organized now then how it used to be…." However, the Norwegian practitioners argued that the new rules that have developed over the years have had both negative and positive impacts on their practice. As for negatives, Martine said, "I think it has changed, now there is a requirement to use a standardized journal treatment plan, and it specifies a diagnosis, and it specifies also to take referrals from doctors who are geographically [located] where one has their practice. So in a way… one has a requirement to take in patients from them and also prioritize them." Roar elaborated on how these new rules prioritize the standardization of treatment in the outpatient clinic setting, "… there's a pressure for assessment. They have to do assessment, they have to do diagnosis, they have to create a treatment plan, and then they try treatments…." Irene also gave some insight when she said, "there [are] rules for that; those and those diagnosis are supposed to be treated within so and so long and so and so long, like depression for instance, so they have guidelines for who to give priority. And it's not enough that you're suffering in a way, but it should also be very probable that you will get better from treatment."

In spite of these negatives, the therapists believed that the new rules also had positive implications. Marius noticed, "… the good thing is that there [are] very few meetings … required now…. Nothing is required anymore so it's up to us how to organize our practice…." Irene mentioned the new requirement of reporting, "three times a year we have to send in how many hours, what kind diagnosis the patient has and … so it takes by itself the data from what we are filling in regularly, and if you do it very clean all the time then it is not very much work to just get it finished." I also asked Irene about the recent change in getting clients approved for rehabilitation services. Previously, psychotherapists first had to get the approval from their client's general practitioner in

order to send them to treatment. Now, however, the recent change has placed that power within the hands of the psychotherapists, and they can directly send their patients to rehabilitation treatment instead of seeking approval. Irene said, "yes, and we are very glad for that.… We have always thought that it was very irritating that we could not refer to a psychiatrist… or [another] specialist, that we have to go through the doctor to get that, … so we are very happy about it."

Overall, the Norwegian psychotherapists mentioned both the negatives and the positives associated with the new governmental influence. Gleaning from their descriptions, it seemed that the practitioners had a more generally positive standpoint. However, what do these new rules mean in regards to the government's desire to make Norwegian practitioners more efficient?

5.2c Efficiency Standards

Marius: "… how can we work cheaper and more efficient…" Roar: "… there is no method that is completely [efficient]…" "… there's no variety anymore."

The Norwegian psychologists often discussed their experience with the government and its desire to make them more efficient. Indeed Marius said that the government is constantly working with, "… how to organize us, how to get the best out of us, how can we work cheaper and more efficient; they're working with these things all the time." The preferred method of the Norwegian government, according to Roar, appears to be the implementation of standardized care packages. As mentioned before, Roar says "standardized packages [are] the dream," however, mystery clouds what these packages are, "we don't really know, but it has … a flavor of using evidence-based methods…." However, Roar has an issue with evidence-based treatments because, "… from my point of view there is no method that is completely [efficient] because as I've said somebody is not helped." Roar's argument cast a shadow of doubt on the government's ability to make therapists more efficient.

However, regardless of how therapists personally experience these new efficiency measures, they are still required to submit evidence that they are maintaining the level of efficiency that the government requires of them. Marius said, "… now, three times a year, they would like our numbers and they do quite a lot [of] statistics, and we have … to send in our results of the year.…

They're gathering all of the information about patients in Norway, and they are doing … research about it."

In various ways and using different words, these psychologists raise questions as to whether or not the government's efficiency standards have improved care, or if they have slowed down the therapists' ability to serve their clients. This then leads us to the question: how has the one-two punch combination of new rules and efficiency standards shaped how supportive or limiting the therapists experienced the government to be? Do Norwegian psychologists still have a generally more positive outlook, as they did in regards to the new rules? Or is their new found interface with the Norwegian government more limiting than first believed?

5.2d The Norwegian Government's Power to Support
Marius: "… the best thing is they have … helped us get better communication…" Roar: "another good thing I think … is that the patient owns the medical journal…." Martine: "I am very thankful to live and work in Norway."

The Norwegian government, according to the interviewees, does play a supportive role in their practice. In fact, Irene mentioned that governmental regulation, "… in a way … could be good because you have 8 weeks a year that you don't have to have patients, and then you can have vacation and then you take more courses or further education…." Marius stated that he believes governmental interference to be positive because:

> … the best thing is they have … helped us get better communication with doctors…. I would say that's the best thing. So you are cooperating better with the patients, for instance, if somebody needs … some kind of social care help from NAV I would have to sometimes talk to the doctor, … [and] the doctor would … send me what he or she would like to write about the case, so we are … showing each other what we are doing and how we are thinking, so in that way we help better the patients, I would say.

The informants also mentioned that while the government does regulate their work, they do not believe that the government is critical of how they carry out their therapeutic work. Marius said:

the government has said that you can have this and that long holiday every year … but you have to have so and so many patients, … but they understand that they can't demand the same thing of everybody…. The number [required] every year [is] 1,050 consultants… you had maybe 800, … the government will not … warn you saying "hey you are working all too little" … something can happen, maybe one year [you] work really hard and have maybe 1,100, and the next year 900, and it's natural too because it's life…. They are good at … not running after small deviant things….

Irene also reported that governmental regulations do not impact enough upon her practice for her to lose control over how she worked with clients. When asked what happens when she has a client who is not ready to graduate from therapy, she said, "It's up to me… [if] they need twenty years I can say that if I want to." She also pointed out the benefits of being required to utilize briefer forms of therapy, "… I think for myself I still have too many people … I should have shortened therapy for." According to Irene, governmental interface allows her to negotiate treatment in a way so that patients who require longer-term treatment can and do get what they need, while those who are more apt to receive brief therapy are filtered out of her client pool.

Overall, the consensus seems to be that governmental interface keeps therapists in better communication with the other specialists with whom they need coordinate care. Additionally, they reported that it keeps them honest in their work while allowing them leverage. Martine exemplifies the overall attitude of Norwegian psychotherapists in relation to governmental interference when she said, "I think it is very good and … what is considered a problem [here] is a luxurious problem compared to what it is in the United States…. I am very thankful to live and work in Norway."

5.2e The Norwegian Government's Power to Limit

Roar: "… on the individual level you do not know which client gets help and which client does not get help…." Irene: "… the government doesn't want to have enough specialists…." Marius: "you can be a psychoanalytic person … but they don't want it so much anymore."

In spite of the Norwegian government's power to support their practice, the interviewees also discussed the ways in which they believed both they and their clients were constrained by the Norwegian government. In fact, Irene mentioned, "we sort of feel like we have got a lot more administration, and [we're] not getting so well paid for it…. They are sort of [treating] us as if we are employed, but we [aren't]…. [It is] … more regulated than it was…." The administration and regulations that the Norwegian government imposes upon the professionals develops out of the requirement for them to employ evidence-based methods. However, according to Roar, this is not the most effective way to regulate their work, "if you have an evidence-based method, it's evidence that some are helped and some are not helped. That means that on the group level you have an effect, but on the individual level you do not know which client gets help and which client does not get help…." As a result, Roar argues that the government's limitations excludes certain clients from experiencing effective treatment and relief. He also discussed the implications of assessment, "I have had many young kids who entered the outpatient clinic, in the out clinic you need to do an assessment, and the assessment means often to have them fill out questionnaires, and there are also questions about functioning, negativity so I met a lot of kids who drop out of treatment because they don't like the assessment or they feel tired by the assessment." Again, due to the government's pressure to lead with assessment, Roar believed that his ability to keep his clients engaged in therapy was limited.

Marius mentioned that he believes that the requirement for clients to seek their doctor's permission first before they can receive treatment is limiting, especially for clients who have experienced some sort of trauma. In these cases, he said, "… if [there's] any[thing] traumatic I would say the person should come in right away. I try then to shorten the waiting time more … drastically but you never know how fast it should have been, and you are obliged to think about how urgent it is so you let some people wait longer…." Roar also pointed out how government limitations do a disservice to the individuals they are supposed to serve, "… some places you have some treatment, but it's limited. So what's happened is that there are these families who need more than the outpatient clinic can give." Both Roar and Marius indicated that the limitations the government enforces carries ramifications for the clients who do not fit the normative expectation. In other words, clients who need more than what standardized care can offer fall through the cracks. Marius experienced

governmental demands for efficiency as limiting the type of modality psychotherapists use, "you can be a psychoanalytic person and work like that too, but they don't want it so much anymore…."

Because Martine has her own private practice, she does not experience the same limitations that the other interviewees do. This is not to say however, that she does not limit herself. She mentioned:

> there are limits to what I can use [my] time on with every patient…. I might have to have meetings with NAV or doctors or with treatment institutions. These types of things are difficult for me to do because I have to go out of the office and go to a meeting and do something that might take two or three hours where I don't earn money … so those patients that really need that level of care are not ideal for my private practice, and I really don't have those types of patients…. I can't offer them the level of care that they need.

Whether one works as a public mental health practitioner or as a private one, limitations are to be expected. However, the main difference seems to be whether or not these limitations negatively impact the therapist's ability to care for their patients. In addition, private psychologists choose to limit themselves due to fears of burnout, not because they wish to improve the efficiency of their work, contrary to the desires of the government. How then do these limitations add to the pressure Norwegian psychologists experience from the outside?

5.2f Pressure from the Outside & the Strong Voice of the Therapist
Martine: "I have decided that I won't have more … because it does [create] a type of pressure." Marius: "I liked the pressure…" Irene: "… we feel that we do something wrong if we don't have enough people long-term." Roar: "… that's heavy shit to sit in and becomes even heavier when you have this third person on your shoulder…"

Regardless of whether or not the therapists were supported or limited by the Norwegian government, they all told of experiencing pressure. Although she works for herself, Martine described a situation where she experienced pressure, "I work with … twenty to twenty-five patients a week … but I have decided that I won't have more than that because it does [create] a type of pressure." She then went on to say that she does not allow this pressure to manifest into

stress because she controls how many clients she sees, "… I have set up an appointment book … so when it's full, it's full and then it's a no. It's a little type of strategy." Because Martine controls her own practice, she experiences pressure and stress differently than public practicing psychologists. One thing differentiates her from the rest: the outside third party has not entered Martine's therapy room.

In contrast, Marius reported that "the government and doctors … like to press us to work … more for them….", and "… they press you to learn new things all the time." Irene also discussed the pressure she experiences:

> we feel sort of squeezed because they, in a way, want us to take patients on a very short notice, and that would be really great because then you can get the problem [solved] and its acute, but they also want us to take the ones at the district center … and they think that this patient has to go to therapy for maybe years, and then they're sending all those [patients] to us. But then of course it does something with our capacity because if we have so many going for such a long time … we can take in very few new [patients].

However, in contrast to Irene, Marius mentioned, "… they want us to be more efficient…. The doctors would like us not to be stuck with our patient because then you can say all the time "oh my private practice is closed because I don't have room for new patients" and if everyone should say that, it stops.… You don't have room for new patients, and it shouldn't be like that." It seems that although Marius acknowledges the outside pressure he experiences, he also understands the justifications for doing so. However, this understanding was not shared by all those psychologists interviewed.

Roar said, "… I think why I stopped clinical is also that there is high pressure." Roar goes into further detail about his time spent working at an outpatient clinic, "…the outpatient has a gate control system so that means that the pressure you feel in an outpatient clinic is much more concrete in the sense that then you have to do things, and if you don't do it … the boss will say you should…." Furthermore, he said, "there is always a pressure that we should work a shorter time…. Somebody called what we're doing …Rolls Royce therapy, that … we were spoiling the families

because we gave them what they wanted. It's not Rolls Royce therapy, it's hard work actually both for us and for families."

Irene also discussed the time pressure she experiences, "…of course you have the time pressure on you, so … it is there and you think "oh I have to stop this therapy, it's not going very well…."" However, there appeared to be concern over whether or not putting a time limit on therapy is beneficial. Irene said, "it's hard to stop someone who is not getting so much better, and you feel you're … very supportive for them and you mean a lot to them and they have so few people, and it is very hard to say … [that] the treatment is not helping…. But maybe it's an important thing that I am a person in that patient's life, and it is very hard to stop some of them…."

Marius, on the other hand, believed differently:

> when I first started we were given … twelve hours for doing this kind of psychological work. We could apply for more hours after these twelve hours, but we would have to apply and somebody would have to say yes, but I kind of liked the pressure … that time [pressure] put on the patient and me like "hey you have to work this out within twelve hours." Now, since [treatment] can also easily be free, … you can [either] come or you cannot come, or you can work hard, you can focus and prepare yourself for the hour or not, and I think some people are taking the whole thing … for granted…. Therefore, I liked the pressure and I could say "now we have five more hours to work on this problem so what's the important thing, and what can you do in the meantime now?" I can't do that anymore.

Despite his favorable view of time limits, Marius also expressed concern about the time pressure he experiences. When I asked him if he is pressured to get his patients in and out of treatment, he said, "sure, especially if they need … about three [or] four years…. A person like that is blocking one place." He adds, "… [but] of course because it takes longer time to heal it heal the problem." Irene further elaborates on the pressure she experiences when it comes to seeing as many clients as she can, "it sort of can feel like a pressure. Especially if you get so many people referred to you that you cannot take [them all] and everybody is sort of dissatisfied because you take so few, and then it's hard to get the people fast enough through." She goes on to say:

… we feel this double pressure. For example, we should have a lot [of patients] but we should also have people in long term therapy…. If we ask "should we not take more long-term therapy patients?", they say "yes, yes, yes, but you should also take as many patients as you can." So the pressure we feel is that we do something wrong if we don't have enough people long-term and feel also at the same time that we should have taken in more patients.

Roar mentioned that the pressures that he experienced came from the government's desire for them to implement effective treatments. First he mentioned how the government attempts to get the therapists to use more effective treatments, "… there is a [great] pressure at the moment that you should do assessments, you should do the diagnosis, and you should create the treatment plan, and then … try treatments." Then he said, "the pressure from the outside, the third person in the room, the government the health authorities, is that their message is mixed I think. For instance, I see that the health director says now that we need to use methods that are [effective]…. The big issue for me is how to communicate that up in the system, and I think up until now that has been very difficult…." Roar then went on and expressed his overall concerns about the government's methods:

The worry is the decisions on what to do in the sessions is placed outside. So that means that the third person, the third position, is no longer somebody who, sort of, in my job, I knew … but this third position that was representing worry: should I do things differently? Because I work with cases where we don't see change, … I have to ask "is that because what I do is not helpful?" and that's heavy shit to sit in and becomes even heavier when you have this third person on your shoulder who says you should do an evidence-based method.

One thing becomes clear: Norwegian psychologists do experience pressure from the outside. This outside influence makes them question whether or not they should see a certain type of client, and whether the care they provide is "good enough." In turn, these types of doubts confuse the therapists and leaves them questioning whether they are capable of providing adequate treatment. How then

do Norwegian psychologists go about voicing their concerns when they are pressured by the government in ways they believe are wrong and/or unjustified?

One thing every interviewee in this study reported as giving them authority over the outside influencer was the power of their own voice. However, this appears to be a relatively new luxury. In the past, according to Marius, "we were … too much on the side of what's going on…." Roar also mentioned, "…in the 70s and the 80s and the 90s [psychologists] did not have any position of power in the system, it was the doctors and the nurses who were running the show. Psychologists have, in our union I think, systematically managed to move us into power positons…."

These new power positions have allowed psychotherapists the opportunity to voice out their opinions when they do not agree with the government's interventions. Indeed, Marius said:

> while the government could be stupid enough to say it … the psychologists as a group would not accept it, and they would manage to fight it. Because like [with] some of the things where they try to make us more efficient, [they're] not taken from the inside; they don't know enough about how you have to work as a psychologist, so therefore you can say "well I do understand what you mean, but it's not working that way, so the answer is no, we cannot do it." And then they can't argue anymore.

Irene pointed out, "… we [are] more private [than] before, and they cannot … treat us like we were employed…." Due to their nature of employability, the Norwegian psychotherapists do not take kindly to demands that they are not comfortable with. In fact, Marius said about the relationship between psychologists and the government, "we can work *with* you, but we can't work *for* you." Roar credits his ability to stand up to the powers at be as, "… I've been lucky working in the place where I've been allowed to do things outside of the box, and because we're old and stubborn and have the privilege of age and experience…." Irene reiterated the same sentiment when she said, "… we are very stubborn as opposed to … conservative … therefore we do very much as we like." As an attest to this tenacity, Marius discussed his experience with a new program he has been trouble logging onto. I asked him if he experienced pressure to get it solved quickly, he said, "no I

don't think so because I don't give a damn. I send what they asked, and I forget it afterwards…. It's a thing I have to do but I if it's good or bad I don't care."

The voice of the Norwegian therapist goes beyond their tenacity. In fact, Norwegian practitioners are equipped with the ability to direct themselves and their practice despite the government's attempts to gain more control. Indeed, when therapists believe that the government has overstepped their boundaries, Irene said that psychologists are notorious for putting up a fight, recently "psychologists have been fighting for more rights…." Marius elaborated upon this idea when he said, "psychologists are maybe much more out there, and we are listened to in another way and we are preached [to] in another way, and so… I am not sure the government will manage to dictate … the content because that's not possible and it's been great protests, strong protests."

It becomes evident that Norwegian practitioners manage themselves according to what they deem best. Indeed, Roar said, "… there has been a pressure to do things differently but we haven't done it…. We are supposed to finish cases after a year, one-and-a-half, two years. The longest I've worked with a family was thirteen years." Marius also voiced how he justifies doing what he classifies as best, "…you can make it a pain in the ass, but you don't have to. You can listen and then you do it your way anyway…. So for me it's not a big problem…."

When it comes to the pressure he experiences from the Norwegian government's demands to use standardized treatments, Roar said, "…the relationship between diagnosis and method is not the decisive relationship. It has to be put into a broader context where you look at patient characteristics, intentions, preferences, cultural issues, and the skills and knowledge of the therapist." Because he believes this, Roar treats his clients according to the direction he thinks is best, rather than caving in to the government's expectations. He further exemplified this point when he discussed how he tailors treatment to his client's needs:

> …because this way of working does not help every family that are sent to us, that means that we have developed a way of working where we say that we try to follow the family. Our first question is "what do you want us to do?" We use these feedback scales to help us and then basically we try, within ethical limits, we try and do what the family wants us to

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do. So if a referring agent says there is … a conflict between mother and father, for instance, when we ask the mother and father [and] they say the problem is the school, we will follow the parents and work on the school issue, and we will not start to work on the couple conflict before the family introduces this or if we see that the conflict interferes … [if it does, then] we would ask them "is this an issue you need to work on?", but if they say "no, we will manage," we will leave it.

Marius epitomized the strong voice of the therapist when he said, "they would like to control us more, but I don't think they can, and I don't think it's so easy to do either…." However, even though these psychotherapists tell of having the luxury of speaking out, will the power behind their own voices last forever?

5.3 The Third Actor in the Therapy Room: Similarities and Contrasts

5.3a Public Versus Private Distinction

Paula: "I think working in the community mental health setting is a lot more demanding." Julie: "I never asked about finances before this job." Martine: "There's a flexible opportunity that private care gives…."

Both the American and Norwegian psychotherapists made distinctions between their experiences working within both the public and private sectors. The Americans, however, had mixed experiences. Paula believed that working under MCOs requires less effort than working at a public institution while Julie suggested the opposite.

Paula argued that working in a public mental health setting was far more stressful than working in her own private practice:

> I think working in the community mental health setting is a lot more demanding. Clients are needy; clients have multiple needs, and lots of different kind of stressors that sometimes you can help and sometimes you can't. You are also working in an organization, and you have to deal with the politics and sickness of the organization. You also have more

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paperwork to fill out because others want … data from different kinds of things, so … there's a lot more paperwork to fill out, more need, all the stressors of being in an organization…, and I think all that just makes things really difficult….

Paula went on to say, "… the community mental health setting is a whole different thing. There's a lot of pressure there. Usually therapists have burnout … low salaries, lack of investment in making employees happy and taking care of them, high caseloads, high need clients, lack of proper training, and high productivity." Why did Paula believe that community mental health care was subpar? She clarified by saying:

there is a number of ways in which community mental health is very constrained, and it has to do with having to provide services to the people who have the most need, who need … several modalities and different kinds of services, and providing evidence that the treatments are working…. Usually those clinics have multiple funders but oftentimes they demand data that shows that there is effectiveness in the treatments; that shapes the kind of treatments that they offer.

Paula then argued that her experience working in private practice was the polar opposite of public care, "in private practice it is not like that. It is actually my experience a lot less constrained…. I handle my own business, so I don't have to provide the insurance company with information about my operations and about how I work and … I basically provide the service how I want to provide it…." Paula also distinguished between the technicalities of paperwork in her private practice and the community based setting, "[under managed care] it's a formula. It becomes writing in a formula so … you just give them what they want. In agencies people really don't have a choice…. Their supervisors look at their paperwork and they want it in that way so they have to."

She did acknowledge however that, "there's always limitations with insurance companies because they are interested in the gathering of certain information, and they sometimes have an impact in what kind of treatment is offered so there's … always the impact of how much reimbursement they give, how much they pay for services. So that's always a constraint with any insurance…."

Julie, on the other hand, reported having a different experience with the public mental health care system. When I asked her if she was ever limited in the amount of time she could spend with her clients, Julie said, "no…. Families, you know, have life to do [so] it was rare that I could see them any more than once a week, but if they were willing and it could fit in my schedule I would see them." Julie also mentioned that when she practiced publically, she could focus solely on therapy:

> I never asked about finances before this job…. They had … billers who were experts at knowing how to enter data into the system, and that's how they would get reimbursed. So I never was in the financial piece at all…. The county of (place) would pay the group home … to have the kid there [and] … that child was to receive weekly individual therapy, and that was my role; to give them therapy…. I personally never had to think about billing….

I followed up by asking Julie if she had more freedom working at the public agency than she does now. She said, "Clinically, yeah…. There was no authorization process."

All in all, the American psychologists appear to have mixed opinions as to whether working privately creates more clinical freedom than working in a public setting. However, Martine's experiences in Norway has led her to believe that while there are differences between the clients and workday demands, there are no differences between the quality of care received under either service. Since Martine works within her own private practice, she was able to provide insight into how working in the private sector compares with the public sector in Norway. She said, "[patients] come themselves…. All of the patients that come to me pay in full for the appointment." Martine also noticed a difference in the clientele she services:

> I think the main difference is that the group I would with now are better functioning. You can say that they are able to get through things better, [and] have more resources than the group I worked with in the 1990s. There was a larger portion who had more serious problems … and that were disabled and had large problems and weren't going to get much better. There was a bigger proportion of those patients. Now it's like all who come to me are people who are well socially established and make pretty good money or have parents with money, and their psychological condition is often on a healthier level.

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Martine also argued that private therapy, "gives a bigger chance for specialized [care] so the patients get help when they need it and they get as much help as they need. There's a flexible opportunity that private care gives…."

As far as working hours go, Martine said, "For every hour I work with a patient you can say that that is the only work I must do. There's also a little office work or administration in addition but [if] you work publicly then you have working hours; you work from 8 to 4, for example, 37 and a half hours a week…., so I work less hours but I work much more intensive…." However, Martine's freedom over her workday translates into loss of income on the days that she is not in her office, "it's difficult when one works for themselves…. If I am at a weeklong course, then I lose a week's income. In addition, I have to pay for the course and I have to pay for the trip. A very big and expensive investment…."

All in all, Martine told of recognizing that, "I work in a type of luxurious sector. Those who have money … prefer to go private instead of going public when they have the chance, and so there are some who choose that, but I think that those who are referred to public care also get good [care]. So I don't think that there is a huge unfairness."

While it is not clear in the US, it seems that choosing to work privately does not have an advantage over the other. However, it is important to note that differences between the public and private sectors, both in the United States and in Norway, do exist.

5.3b Paperwork

James: "I just have to provide more time for doing paperwork…." Paula: "I just have to fill out a form… it doesn't take me a lot of time…." Julie: "it's literally taking up time from the session…." Roar: "… I'd say I'm probably one of the best paid sectaries in the hospital with the worst training…." Marius: "It's much more now." Irene: "I think all of us feel … it's a little bothersome."

When I asked the interviewees what types of adjustments have they had to make as a result of outside influence, the resounding response from both countries was paperwork.

As James put it in describing this experience, "I just have to provide more time for doing paperwork and more timely paperwork, so for example, before I might be behind in my notes maybe a week or maybe two weeks, like I would see five or six clients a day five days a week and I might not have done all of my clinical notes…. With managed care … you have to have it done within 24 hours of your session." Paula mentioned however, that her paperwork requirements do not take much effort, "I just have to fill out a form…. It's detailed but it's the same form, so once I learned how to fill it out I just do it and it doesn't take me a lot of time, and now I know how to do it." In spite of its ease, Paula still chooses to limit herself, "…that's one of the reasons why I don't take on more insurance because I don't have time to deal with the paperwork…."

Unlike Norwegian practitioners, American psychotherapists are required to maintain their paperwork for audit purposes. James said, "every therapist is audited to some degree. They [want] to read the details, … did I do my notes on time, does this treatment plan fit with the diagnosis, what are the issues to substantiate that…." Julie also discussed paperwork and audits, "what I did was I documented what we did in the session. There was a certain format for that … and then I submitted [it]…. If they were ever audited that's what they would need to see, like what time the service started, who was there, what time it ended, and kind of the focus of the session." However, filling out the required documentation is not the end of the process. When I asked how long he had to keep his records for audit purposes, James said, "seven years" because "every time you do billing, … you are saying I have the documentation to substantiate this bill so they have the right to at any moment say "did you really? Let me see it.'"

Because American psychologists working under MCO schemes must document for authorization and reimbursement, I questioned them about whether their paperwork has ever been denied. James said, "I have never heard of someone being denied payment for additional time because we all knew that we had to document it, so … you didn't want to give away your time for free." Paula, on the other hand, had a different experience. When I asked her if she had been denied payment, she said:

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initially when I was learning yes, but I used a service called (name) and basically they're like a middle man between the clinician and the (insurance company) and if it's not properly filled you get an email, "you got to do it again", but I was never denied services or anything. Basically if the form is not filled proper it doesn't go to the insurance, so when I had errors that were actually my errors, I fixed them and then sent it back and then they came back within a week or ten days.

However, this demand for documentation appears to take time away from the client. From her own personal experience, Julie said, "I've had my own therapist who I was using my insurance benefits for, and every once in a while she would bring out this piece of paper and say "well the insurance company needs to know this stuff so I'm going to ask you again" so it's literally taking up time from the session…."

Interestingly, Norwegian psychotherapists have experienced a similar relationship with paperwork. Roar on the topic, "… I'd say I'm probably one of the best paid sectaries in the hospital with the worst training...." The increase in paperwork over the years has required psychologists to document their treatment in a different fashion. When I asked Marius about whether or not he has experienced an increase in his volume of paperwork he stated, "Oh yeah, before it was more to make the billing to the welfare office, … and not so much more. Sometimes you had to write about a patient or send an … application but it wasn't so much actually. It's much more now…."

Roar also discussed this increase in volume in terms of the online format he is now required to use:

> …we have the electronic medical journal system … which is basically a computerized system …but in order for me to do my daily notes in the medical journal I have to create in the calendar the session, and then … when the client has been to that session … I have to do documentation, which means that the client has been there, and that also decides what kind of money the system is going to get for the job I've done, and only when I've done these two things am I allowed to do the medical journal, so this is how the system govern[s] me.

However, it does not appear to always be feasible to input one's notes immediately after a session. Marius said, "I do the paperwork [not in all one] go, but I try to do a little bit after every session because one session is about 45, 50 minutes and I use the last 10 minutes to write right away, but it's not possible because sometimes we have to answer phones or write something or you have to [do] an errand therefore you do it…." Roar echoed this by telling "… what happens in daily life is that there is a high tempo, so after three weeks I realize that I haven't written one medical journal, so I have to take one day and I write it up. I'm not supposed to do that, I'm not allowed to do that, but we all do it. Irene commented on how this balancing act is bothersome for Norwegian therapists, "I think all of us feel, at least the older [ones] like me, … we think it's a little bothersome."

It becomes clear that the practitioners from both countries believed that paperwork gets in the way of their work. For Americans, if the paperwork is not filled out properly, then their client may not receive care, or a random audit may turn into a major crisis if documentation is not properly managed. In Norway, however, paperwork requirements are still new, but this does not mean that Norwegian practitioners do not experience the same limitations in their practice. One thing appears to be certain as evidenced by their comments: paperwork requirements does take time away from the therapy session.

5.3c Justifying the System

James: "well, people do get service." Julie: "when the system works, when it provides services it's very good." Martine: "maybe it is good that someone checks and creates certain demands." Irene: "I think it's good [that] you have to write the evaluations you do during therapy…. I think that's actually making better therapy." Roar: "I think they're very good at [encouraging] service user participation." Marius: "They tried and managed to make the whole thing more efficient."

Psychologists from each country rationalized the system they work under in different ways. Interviewees from both countries justified their systems by stating that citizens do get care. However, interesting differences emerged.

James discussed how the implementation of managed care has curtailed the stigmatization that was once associated with mental health:

> … people started being taken out of mental hospitals … and we were trying to help people live in the community and become productive people instead of warehoused in an institution, so … instead of you know "put 'em away in an institution because they're acting weird or they seem weird" it's like "yeah but that's my mom or my dad or my brother or my sister and … they're not like that all the time." so there [was]… more of a community involvement in saying "look, these are our peeps, these are our family. Let's do something better for them than put them in a warehouse."

James also justified the system by mentioning the inequalities of care prior to MCOs, "I think before managed care it was all private pay … and a lot [of insurance companies] had, like three sessions, very strict limits that were pretty much not negotiable…. Now suddenly you can have sixteen or twelve; one a month more or less, then you have expanded coverage, and before it was like if you don't have insurance you're SOL (shit out of luck)." When asked about the positives of the managed health care system, James said, "well people do get service. People who would not otherwise be eligible get service and they get service from qualified providers…."

Similar to James, Julie also justified the MCO system by mentioning its accessibility:

> there's some insurance … plans that have excellent benefits … like 100% coverage, deductible doesn't apply. I have a client that came in today and her benefits are a hundred percent covered … so she's going to be able to get treatment for as long as she needs at very minimal investment … not any out-of-pocket costs…. There's always a copay but still, when private practitioners charge anywhere from sixty-five, eighty-five, a hundred, a hundred and fifty, that's a significant reduction. So what I'm saying is that mental health care is accessible because people have insurance …. If you don't have insurance, that's pretty cost prohibitive for most people.

Julie also suggested, "I don't think people could ever afford out of pocket…. [There's no better] feeling than to sit with somebody, hear their story know their need, be able to call the insurance company and have them say "okay I'll authorize ten days" and you call the person and you say "come on in tomorrow." So when the system works, when it provides services it's, it's very good."

Regardless of these benefits, both practitioners still had their doubts. When I confirmed her previous comment by saying that having a system is better than no system, Julie responded "that's right, that's what I keep telling myself" However, James captured the overall sentiment when he said, "I'm glad we have it for the sake of the clients and our population. I wish there was a way for there not to be so much intensive paperwork and yet I understand the rationale for it so I don't like it, but I accept it as a necessary evil."

Norwegian psychotherapists also argued that the government was justified in their practices. Martine said, "personally, I can say that … maybe it is good that someone checks and creates certain demands." Irene reflected on the benefits of the new journaling requirements by pointing out that, "I'm glad I'm doing this regularly now because especially since I am now getting older [I don't] remember so well. So I think it is very good to be able to easily look it up, and I think it's good [that] you have to write the evaluations you do during therapy…. I think that's actually making better therapy." Irene also mentioned the benefits of brief therapy:

> it's really nice to be able to decide yourself but at the same time we get this problem … where it's difficult to end therapy, especially when they don't get much better…. I remember when I worked at the clinic, I had a lot of restrictions and had to end therapy all the time, and it was easier to end it…. It is nice to decide yourself like it is now but for [those of] us who think it's difficult to stop or say no, it helps that there are restrictions in the system.

Roar argued that the government's hands-on approach also contained beneficial properties:

> …our health minister … underlines the necessity on the service user of being a part of the … treatment, and even for people who are under mandatory treatment…. So I think they're

very good at [encouraging] service user participation. I think he's underlining that we have to know what we're doing, if it has effects; … they want to make priority of mental health and addiction issues, and I also think that their pressure on making the municipality to the central unit of treatment is very important. So there's a lot of good things….

Marius also believed that tying psychologists to the municipality was beneficial, "I also think the government is doing a kind of necessary thing about thinking how to use us as a group the best way and to connect us with the doctors. That's also important I think…." Marius went on to justify the necessaries of the government when he said, "…people working with big numbers would see that more of the groups they wanted should get some help faster. They are also get their work done faster and I think that's what they like. They tried and managed to make the whole thing more efficient."

Irene justified the Norwegian system by indicating Norway's socialistic tendencies, "we have also been rather socialistic you know, so we want everyone to have the opportunity to get treatment…." As a result, the Norwegian informants, like their American counterparts, argued that the government's actions were justified because patients gain access to care. Indeed, Irene said, "it's very good for the patients [to] have to pay so little for going for a long time in therapy. I think that's good, and of course that means I could give therapy [to] a lot more people…." Martine echoed these thoughts, "… it was nice to have social support because it meant that the patients could pay less and I could offer care to people who didn't make good money…." She added, "I think that public mental health [care] is a good option for the Norwegian population…. It's a safe and good base. There's also a luxurious segment that is private… [but] I feel privileged that I can be that luxury … I think it is good for me but I wouldn't want that as the only model. I think it is very good that it is regulated the way it is regulated." Overall, Martine believed that the public care option was beneficial because, "I know that everyone can get treatment … and that is important to know."

Both American and Norwegian psychologists believed that their systems were working correctly because of the accessibility of care that had been created. However, in the United States, the psychologists mentioned that this was only the case if the client had insurance. While in Norway,

the psychologists pointed out that receiving support and care are social rights, and that this extended to mental health care.

5.3d Opposing the System

Roar: "when you have an evidence-based method somebody is not helped…." Marius: "what is evidence-based and what is not? It's a litter hard to say…." Paula: "they do whatever they want." Julie: "can't somebody just voluntarily say "I've never been in this place before, I'm struggling, I need help."

Naturally, both American and Norwegian psychotherapists were dissatisfied with outside interference. While the Norwegian interviewees tended to largely justify the government's interference, they also expressed a number of concerns, mainly with the requirement of using evidence-based methods and assessments. Marius said, "they would like everybody to work … evidence-based treatments, and of course what is evidence-based and what is not? It's a little hard to say because it's like, all of the cognitive things are evidence-based and nothing about the other things." Roar also voiced the same concern when he said:

> …when you have an evidence-based method somebody is not [being] helped…. For instance, let's say 60% [are] helped with cognitive therapy with depression, and 40% [were] not helped. The big issue for me as a clinician [is] when a person comes in to determine which group does she belong to and there's nothing in that evidence-based method that [helps], so you have to do more. So I'm not against evidence-based methods and I'm not against manualized treatments, but what I'm against is that these become gold standards and the [dominant] way of working.

Roar also mentioned his opposition to reliance on assessment:

> … the medical model has a sequence of actions: first assessment, then diagnosis, then treatment plan, then treatment. Where I work we said that you must never start with assessment, you must start with treatment because … the two most important [starting] places for treatment is to meet people in such a manner that they get hope at the beginning

and you have established a working alliance … then you can start to ask … "what kind of assessment is needed here?" So I am very critical to the government's way of underlining this as a sequence…."

Roar further criticized assessment when he said, "I mean that very [literally], that you should never start with assessment, and if you think treatment is to give theory specific ingredients then you haven't understood what treatment is…. But that doesn't mean that you shouldn't do assessment, assessment is very important. I think diagnosis can be very helpful in many ways but you should never start with it."

The Americans made clear their dislike for the MCO system´s business approach to care. As Julie put it, "insurance companies are out to make a profit like any other business." Treating mental health care as a business has left Paula trapped. When I asked her if therapists are at the will of the insurance company she said, "you are." As a way of illustrating how therapists become slaves to the will of the MCO, Paula said, "they do whatever they want. The reimbursement rate was one hundred and twenty-nine dollars and they decided to change it to eighty-nine … so they simply decided to cut thirty dollars out of the fee, and that was it. So they really do whatever they want."

The Americans agreed that the manner in which MCOs treat mental health as a business worked to prevent adequate care. For example, Paula mentioned the difficulties she experienced in getting in contact with the MCO, "they have someone assigned for relationships with therapists, and I never find that person. That person never returns [calls]; it's only email and whenever she wants to answer, so there's times where I ask questions and it's like okay, I'm talking to a black hole here because there's no response when I'm asking, and I can't find this person, and you know, they get away with that." Julie mentioned the waiting lists:

> I can't tell you the number of people that say to me "my insurance company gave me a five-page list of psychiatrists, and I spent three hours on the phone calling them and if they were taking new patients the soonest appointment I could get would be four to six weeks out and I need something now" … so I hear that over and over again. There are just not enough psychiatrists and … that's another issue when people want to try medication, or are on

medication and it's no longer effective they really do need a psychiatrist. The primary care physician can prescribe, but you know that's not their specialty….

Paula mentioned her own reservations when she said, "some insurance companies… are better than others, so some people only have coverage for a number of sessions sometimes. So it's not enough…. Now, of course, the problem is that they always want a diagnosis, so if you want to work with somebody who is not willing to go there, it has to be out of pocket…." However, oftentimes those with insurance who want treatment but do not want a diagnosis cannot afford to pay out-of-pocket fees. Julie said:

> sometimes even with insurance it's too much…. When somebody has an out-of-pocket, there's a deductible which is the amount you give up front, and then the insurance benefit kicks in. Then there's out-of-pocket max usually, for the year. If you have an out-of-pocket max and you reach it, say its three thousand dollars, everything beyond that is covered one hundred percent. So what I say to people is "it's likely in the first two weeks of treatment that you'll have to pay three thousand dollars. Once you pay that there'll be no cost as long as you stay," … and I've had people say to me "I'm sorry, I can't. Three thousand dollars is too much" even though that would cover six weeks of treatment, they just can't do it…. That's the sad part.

The combination of out-of-pocket expenses and the requirement of a diagnosis appears to be a source of opposition for the American practitioners because these regulations prevent clients from obtaining treatment. Indeed, Paula said, "well when you have insurance there's an option of whether you take what they offer, and then you have a diagnosis that you have a record somewhere … or you pay out of pocket, and not everybody can afford to pay out of pocket, and when you can't you have to use your insurance." However, James mentioned the consequences of diagnosing when he said, "… we don't want this documentation to be wrong for this person because who knows what this person is going to need in the future… like for life insurance or even for, you know, applying for a job…." Julie mentioned the same issue, "sometimes people don't want to use their insurances because to get reimbursed from insurance, you have to give someone a DSM-5 diagnosis, and … that's with them for the rest of their lives, and if they lose that insurance … and

they try and get [new] insurance … that can prevent or increase the amount of premium somebody pays if they have that in their history. So that sometimes works against you to get a diagnosis….” When I asked what her clients do when they are in this predicament, Paula said, “if I have a foundation to give a diagnosis I usually discuss with people what the diagnosis will be, and you know, the most interesting thing is most people go with it anyway…. I’ve had a discussion with a couple of people who … really didn’t want it, but they also wanted the treatment because … in terms of finances they really needed insurance to flip the bill, so they ended up anyway going with the insurance.”

Julie formulated her opposition best when she said, “can’t somebody just voluntarily say “I’ve never been in this place before, I’m struggling, I need help.” It’s already hard enough for people to feel that vulnerable.”

Overall, the source of American opposition comes from the MCO’s business model, and their forceful adaptation of mental health care to that model. On the other hand, because mental health care is a social benefit in Norway, therapy cannot be adapted in such a way. However, this has not stopped the Norwegian government from trying to force psychology into the medical model, and as a result, evidence-based treatments and assessment have become the norm. One must wonder, if psychotherapists oppose the methods in which the systems they work under, then why do they continue to do so?

Chapter 6: Discussion

6.1 Organization Theory

As mentioned earlier in the theory section of this thesis, Organization Theory denotes the ways in which an organization is ran. To review, Classical Organization Theory considers organizations mechanical in nature, and best-method solutions not only exist, but the optimum way to discover them is through scientific analysis (Shafritz, Ott, and Jang 2011). Similarly related, Modern Structural Organization Theory contends that organizations are rational, and its primary concern is making progress towards executive goals (Shafritz, Ott, and Jang 2011). In addition, rules, authority, and control are the tools the organization uses to achieve these goals (Shafritz, Ott, and

Jang 2011). However, Neoclassical Organization Theory promotes the idea that in order for an organization to be successful, it must work in tandem with its environment (Shafritz, Ott, and Jang 2011). Out of the Neoclassical perspective emerges Human Resource Theory which states that the organization's purpose is to serve the needs of its public through a collaborative and codependent relationship (Shafritz, Ott, and Jang 2011). In addition, corporate decisions are made openly, allowing its employees the freedom to make informed decisions about their futures (Shafritz, Ott, and Jang 2011).

Using these theoretical perspectives and the mental practitioners' statements, it becomes clear that the MCOs in the United States come closest to fitting into the Classical paradigm while the Norwegian government comes closest to fitting the Neoclassical one. These differences make themselves known in the therapists' descriptions of their relationships with either the MCO or the governmental bureaucracy they work under.

All of the American interviewees told at one time or another the frustration they experience in working under an MCO. Their frustrations came mainly from the power the health care organizations had in dictating to them the who, what, when, and why of their practices through the implementation of cost-effective rules and regulations. This was especially true in their experiences with getting their clients qualified for treatment: James, "the bad experience would be when someone I think is in need but doesn't qualify" Julie: things like [qualification] sometimes doesn't make sense, it's like can't somebody just voluntarily say I've never been in this place before?" However, they also mentioned how other rules and demands, like paperwork, have contributed to the adjustments they have been required to make in their practice, and sometimes, forcing them to devise their own methods to work around the MCO's requirements. Interestingly, Shafritz, Ott, and Jang (2011, p. 338) state that, "organizational cultures that reflect unwanted values, such as hierarchy, rigidity, homogeneity, power based on authority and associations in closed networks, and reliance on rules, restrict flexibility and can be formidable barriers to effecting lasting change." Furthermore, the combination of these "unwanted values" and the closed-system they create prevents the organization from interacting with its environment (Shafritz, Ott, and Jang 2011). In other words, these types of organizations, or in this case American MCOs, remain *out-of-touch*

with the population they employ, resulting in the effects American psychotherapists consider detrimental to their practice and their clients.

For the most part, the Norwegian mental health care providers described relatively positive experiences with their ability to provide care under the control of the Norwegian government. This does not come as a shock when we keep the Neoclassical Organization paradigm in mind. After all, the interviewees did mention that they not only had the power to direct their practices how they deemed fit, in spite of the government's attempts to say otherwise, but they frequently did so as well. This becomes clear when we consider Irene's statement: "we are very stubborn … therefore we do … as we like", and Marius saying of the government, "we can work with you, but we can't work for you.", and Roar, "we're old and stubborn and have the privilege of age and experience … I haven't been so worried about the pressure." This type of back-and-forth communication the Norwegian professionals described reflects an open-system. In systems like these, "theorists see organizations as always-changing processes of interaction among organizational and environmental elements" (Shafritz, Ott, and Jang 2011, 401) which allows the Norwegian government to remain *in-touch* with their employees and allows psychotherapists the freedom to remain in control of their practices.

However, I must note that Norwegian psychotherapists have begun to acknowledge the coming governmental takeover, and have taken a similar standpoint towards the government's new rules, which closely resembles those impacting the American psychotherapists. This is adequately reflected in their apprehensions towards the future. Recall that Roar said, "there are dangerous signs of what is happening, and that means that you have to be on your toes looking at these dangerous aspects of neoliberalism, of standardization, of evidence-based methods…." Shafritz, Ott, and Jang (2011, 298) warn that "any attempt to utilize power outside the range of power will tend to reduce the power." This seems to be the current status of the new rules the Norwegian government is trying to implement, according to the mental health providers in Norway. They continue to remain boisterous in their disapproval, limiting the range of power the government has over them. However, Shafritz, Ott, and Jang (2011, 305) also say, "the more legitimate the coercion the less it will produce resistance." Perhaps if the Norwegian government takes up this new position in their quest for more control, then perhaps Norwegian psychotherapists will be less resistant.

All in all, these different theoretical subscriptions reveal an underlying feature that steers the direction of the mental health care practitioner's experience, or what I like to call: the robot versus the pilot. Because American MCOs operate mechanically, and their ultimate goal in instituting the rules and regulations they do is to achieve cost-effectiveness, American psychotherapists have become robotic. Furthermore, the MCO's influence is its primary weapon in keeping its providers in line. Therefore, psychotherapists are cramped into a position where they must adhere to the MCO if they wish to remain on the insurance panel. The threat of removal is enough to scare them into compliance as their livelihoods depend on the income they receive as a managed care provider. As a result, American practitioners do as they are told without voicing their concern, not because they do not want to, but because they have no other choice. On the other hand, because Norwegian psychotherapists remain active in their protests (and have the ability to do so) they are pilots; they steer their own path and make their own decisions. This is made possible through the human resource theory philosophy the Norwegian government promotes, and as long as the communication lines remain open and the bureaucracy remains sensitive to the needs of its employees then Norwegian therapists will remain the pilot. However, if the Norwegian government is effectively able to step in and implement more control over the ways in which psychotherapists treat their clients (i.e. treatment standardization), then Norwegian psychotherapists may lose their pilot status, and slip into a robotic role.

6.2 Evidence-Based Management Theory and New Public Management

To review, Evidence-Based Management Theory (EBT) seeks to find the most effective course of treatment in order to reduce underuse, overuse, and misuse (Walshe and Rundall 2001). In addition, treatments grounded in research analyses are considered the only viable methods of care (Walshe and Rundall 2001; Cochrane 1972). Instead of focusing on treatment efficiency, New Public Management (NPM) utilizes evidence-based methods to enhance organization efficiency (Schachter 1989), and contends that the administration of the organization must be evidenced by scientific measures (Simon 1976).

According to Walshe and Rundall (2001) the language clinicians, managers, policymakers, and researchers use has conformed to the evidence-based philosophy. This proved to be true throughout

the psychotherapists' descriptions of working under third party management. The language of the American practitioners revealed that the introduction of evidence-based requirements has required them to become more conscious of time limits, paperwork, and justifying treatment. Recall that Paula said, "funders drive … in a very powerful way how treatment is provided and what amount." And Julie offered, "the medical model rules", and, "that's why we are trained to be really careful about finding medical necessity." Ultimately, they believed that these alterations have placed the medical decision making in the hands of outsiders, rather than on their own clinical expertise. Indeed, James said, "… it wasn't enough for me to have the training, I had to be able to prove that my treatment plan matched and fit…." The language Norwegian psychotherapists use reflects the adjustments they have made to new evidence-based standards.

Although evidence-based treatment methods rose out of the need to stifle the variations in care and use of ineffective treatments (Walshe and Rundall 2001), their application has been unsuccessful. Indeed, some patients receive suboptimal care that harms, rather than helps. Recall what Roar said about using standardized care packages: "if you have an evidence-based method, it's evidence-based that some are helped and some are not helped. That means that on the group level you have an effect, but on the individual level you do not know which client gets help and which client does not." Furthermore, remember that the push for evidence-based (EB) methods in the US often means that clients are denied care due to the difficult nature of the presenting illness; remember Julie's opioid addicted client who was denied treatment, "recently I had a client… and found out that he had no, zippo, chemical dependency benefits…. Knowing that somebody doesn't have chemical dependency benefits and trying to help them, you run into an ethical dilemma…. This person was not able to access services [and] they were struggling greatly." Considering these two professionals' point of view, we can conclude that the application of EBT in both countries has not been effective in preventing the underuse of treatment as its quest for finding the golden standard of treatment has not been achieved.

Norwegian psychotherapists also mentioned how the use of EB methods has constrained their ability to work. Recall when Roar said, "I work with cases where we don't see change … I have to ask is that because what I do is not helpful? And that's heavy shit to sit in, and becomes even heavier when you have this third person on your shoulder who says you should do an evidence-

based method." This experience is not surprising when we consider Walshe and Rundall's (2001, 435) standpoint: "Some critics argue that the imposition of evidence-based guidelines devalues and subverts the individual clinical professional's expertise and ignores differences in patients' expectations and valuations of different treatment options."

As we recall, NPM also acknowledges the benefits of EB methods. However, the ways in which organizations differ in their values greatly affects how these methods are achieved. Some organizations value budget cuts, performance accountability, auditing, and measurement, and privatization while others value decentralization, freedom to manage, and separation of politics and administration (Gruening 2001). Indeed, Gruening (2001 20) states, "Decisions about administrative structures are political questions and are closely related to political philosophy." Therefore, the ways in which each country adheres to certain NPM values affects the delivery of care. Indeed, the combination of the NPM values and the pressure MCOs attach to the application of EB methods stems from the desire to achieve high levels of productivity, to increase profits, and decrease losses. As a result, power is placed within "a single decision center" (Gruening 2001). On the other hand, the Norwegian government's open system still allows room for psychotherapists to make their own clinical decisions.

Going back to our robot v. pilot concept, we see how EBT and NPM promote the robotic nature of American psychotherapists and the pilot mindset of the Norwegians. Because American practitioners often give the MCOs "what they want", treatment plans become automatic; psychotherapists simply do that which is required of them so that their clients qualify for treatment, and that they are reimbursed for their services. In addition, the competing worldviews of the practitioner (client first) and the MCO (profit), makes it impossible for either party to communicate with one another. Because American practitioners are unable to communicate their perspectives, their concerns go unheard. As a result, they have no other choice but to adjust their work to the demands of the MCO. Thus promoting the behavior of an automatic, detached robot.

Conversely, EBT and NPM in Norway has had an entirely different effect on psychotherapists. The active voice Norwegian practitioners have allows them to be proactive in health policy. Indeed, because of their loud voices, the governmental bureaucracy is well aware of the environment and

its needs. In this case, the environmental awareness allows psychotherapists to keep client and treatment concerns relevant, which in turn enhances the open system flow of information between those inside and outside the organization. Furthermore, the open nature of this relationship fosters participation. The combined effort of all of the above factors encourages the pilot mentality of Norwegian psychotherapists because they are given the power to construct their own therapeutic meanings. Interestingly, according to Peters and Waterman (1982), organizations that emphasize humanistic strategies and culture are more successful than those that value rationality and individualism. However, the Norwegian interviewees in this study mentioned that the traditional health care administration has started to give away to a more neoliberalistic one. As a result, administration, management, and policy become fragmented, and evidence-based methods *control* treatment rather than assist (Gruening 2001). This control ultimately results in Norwegian psychotherapists losing their pilot status.

Overall, we can conclude that the ambitions of EBT and NPM do not adequately match the realities of practice (Walshe and Rundall 2001) as both have not been highly successful in either The United States or in Norway. While countries like the US have established national assessment programs to determine the effectiveness of healthcare interventions (Walshe and Rundall 2001), bridging the gap between research and treatment effectiveness has not been achieved. Furthermore, the neoliberalistic ideology of treatment that has begun to take shape in Norway threatens the pilot status of the psychotherapists. Finally, because organizational decisions, such as EBT and NPM, are closely related to political philosophy (Gruening 2001), therapy also becomes a topic of political debate, leaving us to question the compatibility between the two.

Chapter 7: Concluding Reflections on the Elephant in the Therapy Room

The objective of this study was to examine the effects of outside influences on American and Norwegian psychotherapists and their experiences with these "elephants" in the arenas where they carry out their therapeutic work. Psychotherapists in the US focused especially on processes of joining or of becoming enrolled in different managed care systems. They told about issues involving maintaining their memberships as MHC providers, the adjustments they had to make in their practices, qualifying and advocating for their clients, and the ways in which they maneuvered in MHC systems. Psychotherapists in Norway focused especially on their experiences with

governmental control, new bureaucratic rules, and efficiency standards. They described how the government acted in supporting as well as limiting their practices, pressure from the outside, and the importance and benefits of the strong voice of the therapist. Therapists in both countries shared views of the liabilities as well as benefits of public and private sectors, paperwork, and rationales both for justifying as well as opposing their respective systems.

The American interviewees in this study discussed many of the same key issues as those identified in previous studies. Central among these were problems encountered in trying to comply with MCO procedures (Cushman and Gilford 2000), submitting data and maintaining records (Bittner et al. 1999), interacting with unexperienced case managers (Clemens et al. 2001), putting their client's needs first (Kirschner and Lachicotte 2001), and offering discounts or pro-bono care (Murphy, DeBernardo, and Shoemaker 1998). In addition, despite their concerns about diagnosing and their clients' reluctance to being diagnosed, the Americans did not mention confidentiality as being a major issue as it has been in found in earlier studies (Cohen, Marecek, and Gillham 2006). However, we can conclude that once the MCO has stripped the psychotherapist of their therapeutic philosophy, computerized their practice, and invited them to treat therapy as a commodity, the focus of therapy shifts from what is beneficial for the individual to what is beneficial for the membership; psychotherapy is no longer one-on-one interventions, but rather, hundreds (Shaw and Hoyt 1992). Indeed, recall that Edward (1999, 92) said, "when managed care companies changed our titles from therapists or clinicians to providers they knew what they were doing. This change of names helps diminish the significance of the role and the person of the therapist. It suggests that a clinician is not different than anyone else who has a product to sell."

Unfortunately, due to the lack of a comparable body of research findings in Norway, a similar discussion of the experiences of the Norwegian interviewees in this study and those of previous studies is impossible. However, due to this study's uniqueness, it is my hope that this project will be a pioneer in bringing awareness to the Norwegian psychotherapist experience, and encourage the researchers of the future to look closer at this phenomenon.

Overall, the results of this study showed that a major distinction exists between the psychotherapists in these two modern industrialized societies. These have been earlier touched upon in this thesis with the use of the metaphors of the Norwegian pilot and the American robot. When the government's standards for care do not match those of therapists, their membership in professional organizations, the power of their voices, and their willingness to protest provides Norwegians with considerable clout to influence and shape governmental policies involving practice. They possess considerable autonomy in steering and controlling the work they carry out in the therapy room. In contrast, managed care systems in the US require therapists to adjust and/or fit their practices in accordance with systemic standards. This compliance to these imposed demands translates into a relinquishment of power by therapists to the MCO. Unlike therapists in Norway who possess, like pilots, considerable freedom to steer and to define therapeutic work, the Americans find themselves and their work processes greatly defined, like robots, by powerful organizations whose primary concern is with increasing profits, not the care and well-being of clients entering the therapy room.

The discovery of major differences in treatment philosophies between the United States and Norway is not unexpected. As emphasized by Colmenares and her associates (2016), the realities of clinical practice are culturally constructed, and as a result, these realities not only vary across cultures but also across health care delivery systems within the same community. This is evident in the different manner interviewees from both societies described their experience with their respective elephants. The only questions that remain are how will the elephant in the room continue to remain present and evolve? And, how will this presence affect future therapeutic processes?

Appendix A: List of Interview Questions

Interview Questions for interviewees from the United States

- Can you start with a background of your experience?

- In your practice were you/are you a part of the managed health care system?

- What limitations have you experienced working within the managed health care system?

- What benefits have you experienced working within the managed health care system?

- How did you make the switch from fees-for-services to the managed health care system?

- What kind of adjustments have you made to satisfy requirements, rules, or policies of the managed health care companies?

- Have you ever had to utilize other forms of therapy (i.e. brief) in order to serve your clients due to manage care requirements?

- What other limitations have you experienced due to other demands outside of the therapy room?

- Justifying treatment has often been described as a tug of war between providers and insurance companies. Would you agree with this statement?

Interview Questions for interviewees from Norway

- Can you start with a background of your experience?

- What sort of general outside limitations have you experienced in your practice?

- How has the government limited your practice?

- How has the government supported or encouraged your practice?

- Do you feel like there has been an increase in interference from the government?

- Do you feel this interference is positive? Negative?

- What do you suspect future trends will look like?

- Have your clients been negatively affected by governmental requirements?

- Have your clients been positively affected by governmental requirements?

- What type of adjustments have you made in your practice to satisfy governmental rules/regulations?

- Justifying treatment has often been described as a tug of war between providers and the governmental bureaucracy. Would you agree with this statement?

Appendix B: List of Abbreviations

APA = American Psychological Association

EB = Evidence-Based

EBP = Evidence-Based Practice(s)

EBT = Evidence-Based Management Theory

HMO = Health Maintenance Organization

IPA = Interpretative Phenomenological Analysis

MC = Managed Care

MCO = Managed Care Organization

MHC = Managed Health Care

MHS= Mental Health Services

MMHC = Managed Mental Health Care

PPO = Preferred Provider Organization

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