Managed Care and the Care of the Soul

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Abstract
This article addresses the impact managed mental health care is having on the capacity of psychotherapists to work with people on the most salient issues of living. For nearly one hundred years clinical social work has been charged with the healing and caring of the souls and hearts of millions. Managed care, with its reductionistic, medical model philosophy, threatens this mission. This article discusses ethical dilemmas inherent in a system that is driven by corporate dictates rather than emotional and spiritual health. The authors conclude that entrusting for-profit managed mental health care conglomerates, with their focus on maximizing shareholder profit on preserving the mental health, is at best a risky proposition.
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Introduction

I was told that I was not sick enough to see my therapist anymore. Ten sessions was enough. They said I did not have a problem that they could diagnosis me as having. They told me that being abused by my husband, day in and day out for years, was not in and of itself treatable. I had to be sicker in order to get help. Since I have no money to pay for therapy, I guess I'll have to wait until I get worse. I feel sick inside. I feel like I need help sorting out my life; I need help finding myself again. I don't know what I am going to do now. God help me.

Client of managed mental health care

Unfortunately, anecdotes such as this are not uncommon in the new reality of managed mental health care. Managed care is threatening to turn clinical social work into simply another medical intervention, void of the essence that makes it potentially transformative and liberating (Furman, 2001). Ethics, patient care, and economics have become nearly inseparable, whereas previously the needs of clients were seen as the driving force for health and mental health care.

Clinical social work in the age of managed mental health care is at risk of losing its focus on the human spirit and soul. In fact, some have questioned whether clinical social work can even survive in a managed care-oriented environment (Herron, 2001). Models and theories that focus on true change and transformation, and on the nature of humanity itself, are being negated by managed care corporations' mandate that clinical social work merely focus on the reduction of problematic symptoms. By so doing, therapists neglect the real problems of living that often lie underneath, or at the very least, compound many emotional and psychosocial disorders.

For nearly one hundred years, clinical social work has been charged with the healing and caring of souls and hearts of millions (Saakvitne, 2005). This article will address the value considerations and potential impact that managed mental health care is having on the capacity of clinical social workers to serve people with needs in the important issues of living. When such issues are left unresolved, they often lead to depression, anxiety disorders, and other disturbances, along with increasing levels of chronicity. Prior to this exploration, a short introduction into the history of managed care will lend context to this discussion.

The role of clinical social work in caring of the soul

Traditionally, the care of the soul has been the domain of community structures and spiritual/religious institutions. However, the industrial revolution, and now the current hypertechnological, post-modern revolution, have challenged and altered traditional means of coping, healing, and growth (Kreuger, 1997; Postman, 1992). The ushering in of modernity has introduced new mechanisms to care for the emotional life of those suffering from the alienation and spiritual malaise exacerbated by the social dislocation associated with rapid social transformation. Clinical social work has become one of the keys means by which modern, technologically advanced societies have attempted to cope with the socioemotional and behavioral pains of post-modern existence. At its best, clinical social work is a journey toward growth, wholeness, and self-actualization. It allows people to discover their own truths and connect more fully to others.

Since its advent, many proponents of clinical social work have been concerned with the soul, with the deepest parts of ourselves that make us fully human. From its inception, practitioners have understood that clinical social work is part art, part science. The quality and scope of a human

being's soul, of his or her inner representation of the universe, has long been understood as unquantifiable.

However, these are not the concerns of managed mental health care. Emotional issues and behavioral problems are seen not as part of the gestalt of our being, but as phenomena in and of themselves that can be separated from all intrapsychic and contextual factors. Its medical model philosophy, hidden under the guise of a pseudo-scientific worldview, and its economic bottom line, threaten to reduce clinical social work to a process that is as alienating as the experiences that necessitate its use in the first place. This is the darker side of clinical social work; it becomes a process of social control in which people are treated as broken cars with faulty parts to replace, not as beings with hopes, dreams, and aspirations. In this model, clients are not merely given diagnostic codes that guide the provision of services; they become the diagnoses themselves. Patients in such environments are referred to as their diagnoses. Specific technical interventions are delivered based upon these diagnostic categories to ameliorate behaviors that are seen as problematic, or clients are given medications to treat the symptoms that they are experiencing. The etiology of these disorders is assumed to be biological in nature. Problems that arise from past traumatic experiences, or from difficulties in the match between a person and the environment, are reduced to a numerical code divorced from the meaning that these events hold. A managed care patient is not understood as a spiritual being with goals or a life mission, but as a broken machine to be fixed as quickly as possible. To understand why managed mental health care and its reductionist, medical model has proliferated, it is necessary to understand its historical and political context.

History of managed care in mental health

Before exploring the history of managed care, it is important to position the phenomenon within the international political/economic agenda of neoliberalism. Placing it within this frame helps contextualize what may appear to be a largely North American institution yet is often part and parcel of the global trend toward the dismantling of social provisions for the poor and needy. According to the neoliberalist agenda, eliminating governmental expenditures on health and human services means that more resources will be available for investment, thus creating more opportunities for the poor. According to Walton (2004), neoliberalism is the trend toward a more "vigorous embrace" of market forces and the shift of social provisions from state provisions to the

realm of the market. Through the pressure of international lending and aid organization, neoliberalism has eliminated the opportunity for health care and other social services for some of the most vulnerable groups throughout the world (Inter-American Development Bank, 1997; Munch, 2004). Whereas managed care has yet to make inroads in many countries, it is anticipated that the spread of corporate capitalism under neoliberalism will pave the way for managed care entities as governments turn toward the market as a means of managing social resources (Furman, 2003). Whereas the trend toward managed care in the United States did not begin with a push toward privatization, it is highly congruent with this agenda and has largely been co- opted by corporate entities.

Whereas managed care is a complex amalgam of institutions and strategies designed at cost containment of health, mental health, and more recently other social services, these strategies have been co-opted by corporate managed care organizations. In theory, managed care cost containment strategies would eliminate waste through carefully managing the provision of services. Since managed care organizations are paid a given amount to treat individual members of the population, they should be invested in the health and wellness of all their constituents. Yet, as shall be explored later in this essay, other cost containment strategies have become the mainstay of managed care organizations and have led to a decrease in services for many populations.

In the 1980s, indemnity insurance plans began to offer increasingly generous mental health and substance abuse benefits, and for-profit psychiatric hospitals took full advantage of this trend (DiNitto, 2000). For example, from 1980 to 1986, adolescent admissions to private psychiatric hospitals increased fourfold. By the late 1980s, managed care was called on to reign in what was often perceived to be excessive and often inappropriate admissions. Jellinek and Nurcombe (1993) characterize this irony well: "it was profit that filled psychiatric beds in the 1980s, and it is profit that empties them in the 1990s" (p.1741). This perceived need for the cost containment of mental health services, occurring within the context of the privatization movement of the Reagan era presidency, was one of the most immediate factors that led to managed mental health care's corporatization of mental health services (Dorwart & Epstein, 1993).

While few would disagree with the need to place limits on escalating hospital costs, outpatient psychotherapy and clinical social work practice consisted (and continue to consist) of a fraction of the total mental health costs (Dumont, 1996). However, in their desire to cut costs and

increase profit whenever possible, managed care companies have successfully propagated erroneous myths about psychotherapeutic services--first, that they are ineffective in dealing with mental health disorders and medication should be the treatment of choice; and second, that therapists are seeing clients far longer than necessary, thus robbing clients and the health care system of scarce and needed resources.

The first myth is rationalized by the assertion that most mental health concerns are medical conditions. It is ironic that in managed mental health care, one can be considered either too well or too sick to qualify for services. For example, conditions that are known to be biological in nature, such as bipolar disorder and schizophrenia, are seen as requiring pharmacological interventions only. It is argued that these clients have a medical condition and only need medical interventions. The irony is that persons with persistent mental health concerns are often in the most need of supportive clinical services to assist them in achieving or maintaining healthy functioning. Conversely, managed mental health providers will deny services to someone who defies diagnostic codes. In spite of how they may be feeling, they are seen as too healthy in behavioral terms.

In regard to the second myth, therapy in this country has often not been a long-term process. In his review of research on psychotherapy, Miller (1994) notes that the average length of therapy prior to managed care has been found to be between 8 and 16 sessions. Most therapists know when it is in a client's best interest to terminate treatment. Managed care's limiting of treatment only serves to create anxiety in the treatment process and to risk the health of clients who may need longer-term care.

In addition to limiting the number of sessions, managed care has developed other sophisticated strategies to control the cost of outpatient therapy (Gorin, 2004). The gatekeeping function is one of the most popular approaches. Many managed care organizations utilize "care managers" who screen clients seeking care though a telephone interview. During this interview, clients are required to tell the anonymous voice over the telephone personal problems that many clients are not able to share until after several sessions with a therapist. These initial screenings discourage many people from discussing the full nature of their problems, and they are subsequently denied care because of lack of severity. Managed care gatekeepers are trained to look for problems that are considered "social" in nature, and to refer clients with these non-medical problems to self-help groups.

Further, many clients who are experiencing severe psychological stress may not be capable or willing to jump over all the administrative hurdles that managed care gatekeepers require. Years of research on the importance of accessibility of services have been turned upside down by managed care organizations. They understand that by increasing the number of obstacles that clients have to overcome, merely to be accepted for treatment, many will simply stop seeking care.

Other managed care strategies focus not on the client, but on the providers of clinical social work themselves. For example, one California-based managed care organization pays clinicians a flat rate for three sessions and then a small flat rate for all sessions beyond these initial three. Clearly, this not only sets up a disincentive for more than four sessions, but a disincentive to go beyond the first session of treatment. This has a significant impact on the mindset of therapists. Clearly, many therapists will choose not to work with managed care organizations with such draconian policies. However, others will seek to cooperate with the dictates of the company. It is a sad fact that many social workers have become so dependent upon managed care organizations for their own survival that their values and ethics, indeed, their whole way of practice, has begun to neglect the needs of the client.

The making of therapists

The very training of therapists has been rapidly changing over the last decade in response to managed care (Brandell, 2002; Herron, 2001). Graduate schools in many disciplines have been altering their curriculum to meet the demands and "realities" of managed care. Courses in short-term interventions have begun to proliferate in graduate programs. In fact, many schools are shifting their whole model of pedagogy away from theoretical frameworks that are based on research or practice wisdom to those that are congruent with managed care-oriented practice.

The rationale is simple: since the movement toward privatization and managed care has begun to accelerate, graduate programs must train students to function within the new behavioral health care conglomerate. Few graduate programs seem to be questioning the growing hegemony of managed care corporations. Even in social work programs, which tend to have a strong emphasis on social policy analysis, managed care is often accepted as a reality of practice; rarely are the very principles of managed care and managed mental health care questioned. Ethical discussions seem to center on ethical dilemmas within the context of managed mental health care, not on managed

mental health care itself. This seems to be a clear indication of the tail wagging the dog; neither research nor theoretical considerations are guiding changes in training.

Graduate programs are now focusing too much energy on producing technicians. Efforts toward developing the whole person of the nascent therapist have been fading. This can be seen as a direct result of managed care's philosophy of treating illnesses, not people. Why develop a person, if all that is needed is a technician?

Training is moving toward teaching students how to utilize specific interventions for specific types of problems. What is neglected by the proponents of this new trend in training and practice is the fact that unlike a physician, who administers healing powers though a pill or injection, social workers are the vehicles for treatment. Without a highly developed sense of self, without the ability to understand and work through emotional reactions to client issues, no degree of technical proficiency will matter. Without the requisite work on oneself, therapists will not be able to successfully establish and maintain helping relationships with challenging clients.

This work is essential, because clinical social work's ability to facilitate growth and healing is dependent on a caring and trusting therapeutic relationship. In countering the alienation and disenfranchisement of social dislocation or healing wounds caused by past trauma or pain, the client/therapist relationship is possibly the most clinically important variable in the helping process. Trust, empathy, and caring are requisite components to client change.

Yet, in the new managed care environment, the establishment of such a relationship is often compromised. Therapists are trained to see clients as needing structure and boundaries. Clients who seek additional services are seen as manipulative and are often labeled as being "borderline" or "overly dependent." Needy clients are seen as being troublesome. As a result of its for-profit nature, managed care seeks to provide as little treatment as possible. Therapists cannot entirely insulate themselves from the tension that this creates; relationships with clients will assuredly suffer.

Perusing many journals or magazines geared toward therapists shows the growth of workshops and training in short-term, time-limited, and outcome-based treatment. While few would argue against focusing on successful outcomes for clients, many of these workshops focus on teaching methods of symptom reduction or temporary change. What does a therapist who is trained to perform ten sessions of treatment do with a client who is depressed as a result of a lack

of meaning in his or her life? How does a therapist trained in symptom reduction work with a client who is seeking to decrease anxiety caused by a lack of spiritual connection? In ten sessions, and with the help of medication, a client can be distracted from existential issues and can have some presenting symptoms decreased. Feeling less depressed, yet no more fulfilled or whole, the client leaves therapy with a false sense of security, assured by the "professional" of his or her stability.

No happier, they are at least temporally out of risk. What happens the next time life's stressors trigger their angst and meaninglessness? Clearly, this is hardly the worry of for- profit managed care firms whose main responsibility is not the care of clients or therapists, but the maximization of profits in each fiscal quarter. Managed care companies are frequently bought and sold, with each new owner expressing disbelief at the prior company's ineptitude, making promises to improve the quality of care that are rarely met.

The care of the therapist, the disposable producer

This paper has thus far discussed how these changes affect the training of therapists and the consumers of clinical social work. But how are therapists themselves affected? How will therapists feel at the end of the day when the quality of the helping relationship may be as deep and anonymous as callings across cyberspace? One of the major effects of managed care arrangements is the alienation of therapists. Therapists are becoming alienated from their clients, from their professions, and most significantly, from themselves. Therapists find themselves caught between the needs of their clients and their communities, the clinicians' own agencies, managed care utilization staff, and the very dreams and hopes they had for themselves and their profession. Even new therapists, taught to provide symptom-related treatment, cannot help but to feel the effects of what therapy has become for them, an assembly line job without the opportunity for creativity and meaning. How isolating it must be to spend countless hours with clients and not connect to the deepest parts of their psyche. The dehumanizing process of treating people as symptoms will continue to cause many therapists loneliness and anomie. In the past, many left other professions to become social workers to fulfill deep longings for creativity and to fulfill dreams of service. Today, managed care threatens to cause therapists to leave the field to actualize their higher selves.

Conclusion

Below is a list of some of the potential biopsychosocial consequences of limiting access to services. Focusing on symptom amelioration only can have profound consequences for individuals and families.

- Increased homelessness.
- Increased numbers of divorces.
- Children with more problems in schools ill prepared to handle them.
- Pockets of communities plagued with lower socioeconomic status and mental health issues combined.
- People experiencing inadequate nutrition and thus, greater health needs.
- A greater burden on medical services when those with mental health needs are unable to seek assistance with their own health care needs.
- Increased unemployment.
- A greater burden on community police services, because there are no services available to treat those with mental illness and/or those individuals who have maximized their service capacity.
- Increased litigation when practitioners "miss" an important diagnosis because of an inability to adequately provide services to those in need.
- Under-diagnosing in order to avoid labeling decreases even further the number of sessions one can access.
- Over-diagnosing in order to maintain third-party payment status guarantees more sessions but the effects of the label can be lifelong and negative.
- Increased medicalization of conditions keeps drug companies flourishing.
- Quick fixes overlook the long-term side effects (as in drug research); and finally,
- All of these combines into the overall sense of consumerism that begins to dictate life in post-industrial society.

As managed care becomes the dominant model of mental health delivery, clinical social work is in danger of becoming a process similar to fixing a car. We diagnose problems, apply prescribed technical solutions in a time-limited manner, and return the "functioning machine" back to its programmed tasks. However, contrary to the philosophic underpinnings of managed mental health care, mechanistic metaphors are wholly inaccurate: people are not, and do not function as, machines. Human health is intricately related to the quality of our mind-body relationship. Persistent emotional and behavioral problems do not lend themselves to quick fixes. They are rooted in the fit between the essence of who we are, our souls, and our physical environments. Managed care's insistence on framing the problems of living in medical terms negates both personal and social reasons for our difficulties.

There is no shame in seeking help. There is no shame in admitting that one is having problems adapting. The post-modern world is a complex one. Finding meaning within its ever-changing landscape requires levels of social support and help that are often no longer available to many. Clinical social work, as practiced by those who have strived for the healing of lives and souls, has been a powerful way of helping people cope with these changes. Entrusting for-profit managed mental health care conglomerates, with their focus on maximizing shareholder profit, is a risky proposition.

If psychotherapy and clinical social work liberating activities are to survive, social workers must begin the process of challenging the hegemony of managed mental health care. One of the most salient means by which social workers can affect policy and practice changes is through consumer advocacy. This strategy has the capacity to overhaul the system to listen to the voice of the consumer. It empowers people to take charge of their own healing. It helps to eliminate the person-is-the-diagnosis syndrome. In addition, it helps to maintain the accountability of professionals to their clients instead of to the managed care corporation. It helps to demystify mental illness and can reintegrate/integrate those with mental illness into society. Economic efficiency and the social construction of illness are the focus of this strategy, and it has the potential to shift from issues of mental illness to those of mental health. Finally, social workers are uniquely and logically positioned to undertake this strategy.

Using evidence-based practice and recognizing the constraints of managed care need not combine to further reduce the capacity of people with mental health issues to succeed in obtaining and utilizing services. Evidence-based practice has the potential to assure the consumer that the "best" treatment for the particular situation is being provided. This has the potential to decrease the cost and demonstrate cost effective treatment. The practitioners employing evidence-based practice should always be mindful of the holistic nature of their clients and not succumb to the person-is-the-diagnosis syndrome. Evidence- based practice also has the potential to, particularly across time; demonstrate less need for managed care to dictate severe restrictions in the number of sessions. Practitioners can join with their clients in asking for intervention combinations including pharmacological and psychotherapeutic components.

Policy makers should be made aware that the medicalization of many mental health issues ignores the complexity of people's lives. A person with schizophrenia and taking medication may

still need assistance with tasks of daily living in order to function maximally in society. While medications are certainly helpful in reducing the symptoms of mental illness, there are sociopsychological manifestations in the state of "having a mental illness" that require the support of trained professionals to aid in adjustment. An analogy would be the inpatient treatment of a person with alcoholism without concomitant work with the family and significant others in the environment. When the patient goes home, back to a system that hasn't changed, the likelihood of relapse is great. The inpatient treatment (pill) may temporarily "fix" the "problem," but without support upon return to the environment, both the family and the patient may return to the former way of living and being.

Schools of social work should recognize that the potential for training technicians exists within the evidence-based practice and managed care-based curriculum. Teaching to the needs of the environment can result in practitioners who fail to see the person in a holistic manner. This is most definitely a balancing act, because the coursework certainly must include awareness of a managed care environment and the needs that environment presupposes. To accomplish this task, schools should recognize the necessity of maintaining the person in the environment, ecological perspective while teaching the deliberation process of assessment and intervention. If social work ever strays too far from the person- in-the-environment perspective, there is little to separate us from other mental health professionals. Further, we fail to support one of the fundamental components of our *Code of Ethics* when we do not recognize the uniqueness and integrity of every single human being.

There are many ways for clinical social workers to get involved. Some may choose to join professional organizations that are advocating for change in the current mental health system. Others may wish to do research on the effects of managed care. Yet, others may choose to help empower their clients to seek systemic change. Regardless of what one does, acquiescence and accommodation will only lead to an increase in one's subjective sense of alienation and disillusionment. Our souls, and those of our clients, deserve more.

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