THE IMPACT OF MANAGED CARE ON CAREER SATISFACTION AMONG PSYCHOLOGISTS

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ABSTRACT

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Managed care and third party payors have brought about substantial changes in the delivery of psychological services. This study examined the relationship between managed care or third party payor variables and career satisfaction among psychologists.

A measure of career satisfaction and a survey addressing the practice of psychology were mailed to 700 randomly selected practitioners from the general membership of the American Psychological Association, of which 155 were returned and completed.

The results indicated that psychologists have an average level of career satisfaction. Compared with prior research using a similar sample pool, the results suggest a downward trend in career satisfaction among practitioners. The study identified six demographic variables related to General Satisfaction on the Minnesota Satisfaction Questionnaire: gender, family income, percentage of white collar clients, worktime performing non-reimbursable tasks, worktime involved in utilization review,

and work setting. In addition, the study also found that General Satisfaction was significantly related to six predictor variables: reporting family or couples therapy as individual treatment; selecting a treatment approach to conform with third party reimbursement guidelines; third party payors' influence over treatment decisions; third party payors impact on the treatment relationship; the availability of case managers; and the licensure status of utilization review personnel.

The data supported the conclusion that increased involvement with managed care was associated with a decrease in General Satisfaction. The study also found that Intrinsic Satisfaction was significantly higher than Extrinsic Satisfaction among the psychologists in the survey.

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INTRODUCTION

Over the last five years, a new technology has transformed the practice of psychology (Bloom, 1990; Kiesler & Morton, 1988; Zimet, 1989). The innovation that revolutionized mental health care originated in the medical field in the early part of the 1980's. This new development did not emerge from any scientific or theoretical framework, but rather from the world of finance. The new technology that changed the delivery of psychological services was managed care.

Managed care is a global term, and refers to the regulation of health care delivery by a third party, the payor, usually an insurance company or health maintenance organization (HMO). At the heart of managed care are two core technologies: utilization review and selective contracting (England & Vaccaro, 1991). What makes these two practices so powerful is that they are prospective and proscriptive in nature: they determine what types of treatment the patient will receive.

The net effect of these innovations cannot be underestimated, for they have changed the hierarchy of the health care environment. In the traditional model, the practitioner wielded considerable power, both in assessing the patient and in carrying out the treatment. In the new managed care environment, the power has shifted away from the practitioner, who provides the services, to the party that *pays* for those

services. This fundamental change, from a practitioner-oriented model to one dominated by a third party, has sparked enormous debate over who should determine treatment strategy: those who deliver services, or those who pay for them (Kiesler & Morton, 1988).

The resolution of this debate will have enormous consequences for psychologists, and for the practice of psychotherapy. The provision of psychological services continues to be the primary professional activity of most psychologists (American Psychological Association, 1996). Norcross, Prochaska, & Farber (1993) reported that APA Division 29 members devote 72% of their professional time to providing psychotherapy. Because psychologists spend most of their professional time providing psychotherapy, any force that dictates how therapeutic services are delivered will also have a profound impact on practitioners.

By any standard, managed care has changed the way psychologists conduct their business. In 1983, 89% of the members of Division 29 were involved in fee-for-service private practice (Norcross & Prochaska, 1983). Seven years later, the percentage remained largely unchanged. In his survey of licensed psychologists in New Jersey, Moldawsky (1990) found that more than 87% of the respondents were in solo practice. These proportions changed drastically over the next six years, as managed care plans became the predominant health care delivery system (Austad & Sherman, 1992). Because mental health benefits were included as part of a standard package of health benefits, most individuals received therapy services in a managed care system

(Austad & Sherman, 1992). As the number of individuals covered by managed care plans increased exponentially, HMOs began to recruit providers from outside of their own mental health systems to deliver those services. By 1991, 75% of HMOs used private practitioners to provide mental health services (DeLeon, VandenBos, & Bulatao, 1991). The trend continued over the next two years: Norcross, Prochaska, and Farber (1993) found that only 65% of the psychologists engaged in private practice, down from 89% in 1983. Currently, fewer than 30% of psychologists licensed less than three years are in private practice (APA, 1996a), which represents a 60% decrease in only thirteen years.

As more psychologists worked for managed care companies, the portion of their income that was derived from third parties also increased dramatically. Moldawsky (1990) reported that 90% of the psychologists in New Jersey were not associated with a Preferred Provider Organization (PPO), and 92% received no referrals, or less than 5% of referrals, from HMOs. Less than two years later, Bowers and Knapp (1993) found that 64% of the private practice psychologists in their study accepted third party reimbursement, and the majority indicated that 80% or more of their patients had third party coverage. Nick Cummings, a former president of the American Psychological Association, estimated that 93% of the cases seen by licensed psychologists involve third party payments (1992, in Sinnet and Holden, 1993).

As caseloads of managed care clients increase, psychologists have found that new administrative responsibilities consume their professional time. Reviewing the

results of a nation-wide survey conducted by the American Psychological Association of its members who are licensed psychologists, Newman and Taylor (1996) reported that practitioners currently spend only 43% of their time providing therapy, and now devote 13% of their time to taking care of administrative tasks, including utilization review and reimbursement procedures. In business terms, psychologists spend less time delivering services that earn income, and considerably more time involved in the procedures necessary for obtaining reimbursement for those services.

How have psychologists reacted to managed care? In an early study, DeLeon, VandenBos, and Bulatao (1991) reported that psychologists had three primary concerns related to managed care: 1) patient access to treatment in managed care systems; 2) the quality of care that patients received; and 3) the lack of consumer awareness regarding the shortcomings of managed care systems. Bowers and Knapp (1993) followed with a report on the problems psychologists encountered when working in managed care environments. The primary complaints concerned increased paperwork, decreased fees, and difficulty in getting on panels of approved health care providers. The psychologists in the study also reported problems in obtaining hospitalization for patients and reauthorization for additional treatment.

The reaction of psychologists to managed care can also be gauged by a recent American Psychological Association (APA) survey (Burnette, 1996). The Committee for the Advancement of Professional Practice (CAPP) of the APA Practice Directorate sent a questionnaire to all APA members who were licensed psychologists. As part of the survey, the respondents were asked to list their concerns related to the practice of

psychology. Over 15,000 members returned their surveys, and the results were persuasive.

The top six professional concerns were all directly related to managed care. The concerns were: 1) managed care changing clinical practice; 2) excess pre-certification and utilization review (UR); 3) decreasing income due to managed care; 4) ethical dilemmas created by managed care; 5) fewer clients due to managed care; and 6) exclusion from managed care panels (PPO's). The opinions about managed care transcended professional domains: psychologists across all settings - medical, academic, and private practice - shared the same concerns.

In addition, the CAPP study asked psychologists to evaluate the overall impact of managed care. Again, the results were conclusive: 80% of those surveyed indicated that managed care had a negative impact: 25% indicated that managed care had a highly negative impact; 37% stated that the impact was moderately negative, and 16% indicated that the impact was slightly negative. Again, those results represented the opinions of psychologists across *all* professional settings. Among the respondents, psychologists in independent practice had the strongest reaction to managed care: 89% of the independent practitioners felt that managed care had a negative impact.

The CAPP study provides evidence that managed care has had a direct impact on psychologists, both in terms of lost income and increased interference in clinical practice. While it is clear that most psychologists believe that managed care has exerted a negative influence on the practice of psychology, what has been the

cumulative effect of managed care on the practitioners themselves? Has managed care changed the way that psychologists feel about their work?

Historically, psychologists have had a high rate of career satisfaction. In a 1983 study, Norcross and Prochaska found that 90% of the psychologists in independent practice in their survey were either very satisfied or quite satisfied with their career. When asked if they would choose psychology as a career again, 70% of the sample indicated they would make the same decision. Walfish, Polifka, & Stenmark (1985) asked the same question, and found that 90% of their sample would choose psychology again. In a 1991 follow-up study, Walfish, Moritz, & Stenmark, asked participants from their 1985 study to rate their level of career satisfaction on a Likert scale, from 1 to 6, with 1 representing high satisfaction, and 6 indicating very dissatisfied. The average level of career satisfaction was 2, suggesting that most psychologists appeared to be quite satisfied with their work.

Norcross, Prochaska, and Farber (1993) have provided the most recent data on career satisfaction among psychologists. Once again, the authors found that a majority of the respondents would choose psychology as a career if they had to make the decision again. Replicating the methodology of their 1983 study, a single direct item was used to assess career satisfaction among psychologists. Although the majority of their sample reported satisfaction with their career - 47% were very satisfied, and 36% were quite satisfied - those results represented a 10% decrease from the initial study ten years earlier.

Summary

A review of the literature on career satisfaction among psychologists suggests that they are satisfied with their chosen careers. Although the level of satisfaction has historically been high, there has been a considerable decline over the last ten years. Despite the efforts of previous researchers, the overall picture of psychologists' career satisfaction remains incomplete. Current levels of career satisfaction are unknown. While several studies have investigated career satisfaction among psychologists, researchers have not taken into account the recent changes in the delivery of psychological services. In addition, research has thus far failed to examine career satisfaction in depth. For example, it is unclear which factors contribute to the sense of fulfillment that psychologists derive from their work, and which factors detract from their overall satisfaction with their careers.

The lack of accurate data on career satisfaction among psychologists presents a problem for individuals who may be considering psychology as a career. The scope of this problem can be inferred from the number of individuals who are involved courses of undergraduate study in psychology. According to Clay (1996), psychology is the most popular major among college freshmen who have chosen a major course of study. Similarly, Murray (1996) reported that psychology continues to be the second most popular major overall among all undergraduates, with over 66,000 degrees granted each year. Without current research on the satisfaction that psychologists obtain from their chosen profession, those students will not have the information that

they need to make an informed decision about what they might expect from a career in psychology.

The absence of accurate information on career satisfaction among psychologists has a number of implications for both managed care companies and practitioners. As the cost of providing health care has leveled out among HMOs and managed care companies, patient satisfaction has replaced price differential as the critical factor for corporate purchasers of health insurance (Mahar, 1996). In order to compete effectively in the future, managed care companies and HMOs will need to become increasingly sensitive to those aspects of their business that impinge upon patient satisfaction.

According to Bloom (1990), patient satisfaction appears to be very responsive to the experiences that patients have with their health care providers. If low career satisfaction leads to high turnover among psychologists on a provider panel or staff HMO, the ensuing lack of continuity of care may result in decreased patient satisfaction. Without accurate information on which aspects of their business practices have a positive or a negative impact on psychological service providers, managed care companies and HMOs may not be able to avoid the potential negative repercussions of low career satisfaction among practitioners.

Finally, psychologists fill a vital role in the provision of mental health care. If practitioners begin to leave the field as a result of low levels of career satisfaction, mental health care may no longer be available to large segments of the population,

and the quality of care that patients receive may suffer when there are fewer practitioners to handle the burden. Without accurate information on current levels of career satisfaction, and the factors linked to that satisfaction, the profession of psychology will be ill-equipped to identify problem areas and to initiate solutions.

Statement of the Problem

While the literature on career satisfaction among psychologists established a frame of reference, the research has a number of shortcomings. First, all the studies assessed career satisfaction, a complex construct, using a two or three item questionnaire. As a result, the research has only been able to render a global picture of career satisfaction. The studies were not designed to discriminate between intrinsic and external sources of career satisfaction - in this case, between the fulfillment that a practitioner obtains from providing psychotherapeutic services, and the amount that managed care contributes to or detracts from that sense of fulfillment. So while there is a reasonable amount of historical data on career satisfaction among psychologists, there is no current accurate and comprehensive information, nor has there been any research on the relationship between managed care and career satisfaction.

This study will be concerned with the following two research questions: 1) what is the level of career satisfaction among psychologists who are engaged in delivering psychological services? and 2) what is the relationship between managed care and career satisfaction among psychologists?

CHAPTER 1

LITERATURE REVIEW

Health Maintenance Organizations

Historical background

The original purpose of health maintenance organizations was to provide health care to a greater portion of the population. The HMO movement began in the Pacific Northwest in the early 1900's, when individual physicians were hired by lumber and mining companies on a salaried basis to take care of the health care needs of their employees. The first HMOs were formed thirty years later, during the Depression, when groups of physicians began to contract with municipalities and corporations to provide complete medical care to employees for a fixed per capita cost per month (Bennett, 1988).

In the early years, investment capital to cover start-up costs for new HMOs often came from organized labor or private philanthropy, and these sources imbued the movement with a sense of idealism and positive social purpose (Bennett, 1988). The New Deal programs of the Thirties created an environment that stressed social reform, and these social initiatives were later championed by organized labor in the post-war era. As unions began to insist on health insurance for employees, corporations started to look for an organizational structure that would provide health care to large populations. HMOs fit the need, and provided an indispensable service where none had existed.

The rapid growth of HMOs can be traced to several legislative initiatives in the 60's and 70's. Operating on the principle that health care is a basic human right, Congress passed legislation that created Medicare and Medicaid in 1965 (Kiesler & Morton, 1988). A large portion of the population that had previously not had any health insurance immediately enjoyed full medical coverage. The dramatic increase in the portion of the population that was covered by government medical insurance was inevitably followed by a surge in the percentage of the gross national product spent on health care.

In an initial attempt to contain health care costs, the federal government turned to HMOs as a lower cost alternative to traditional fee-for-service indemnity plans. To promote the growth of the HMO industry, the government provided federal funding to assist with start-up costs. In order to qualify for these subsidies, HMOs had to offer both physical and mental health services, including outpatient mental health care and alcohol and drug abuse treatment (DeLeon, VandenBos, & Bulatao, 1991).

In the 1970's, a second round of legislation led to rapid growth in the HMO industry. The 1973 HMO Act allowed profit-making companies to receive federal financing. It was followed in 1976 by additional legislation that required corporations with more than twenty-five employees to offer a health maintenance organization as a health care alternative (Flinn, McMahon, & Collins, 1987).

These federal initiatives were extremely effective. In 1970, there were only 33 HMOs in the United states; by 1988, the number had grown to 659, and 62% of the

new HMOs were for-profit enterprises (DeLeon, VandenBos, & Bulatao, 1991). The rapid increase in the number of HMOs had its desired collateral effect: the percentage of the U.S. population that was served by HMOs tripled in the '70's, and tripled again in the '80's. By 1988, 33 million Americans obtained their health care through HMOs. The growth of HMOs continued at a phenomenal rate through the end of the decade, when 65 million Americans had their health care delivered through HMO services (DeLeon, VandenBos, & Bulatao, 1991).

Current HMO trends

HMOs and the profit motive

A number of authors (Dorwart, 1990; Zimet, 1989) have observed that the most important trend in HMOs is a new emphasis on competition and profit. Bennett (1988) observed an "increasing domination of health care by those whose primary business is the preservation and increase of capital" (p. 1546). As HMOs shift the focus from their original social objectives and towards a new emphasis on business, health care has become a commodity, and individual components, such as mental health care, have now become "profit centers". The move towards profitability has been pervasive: Shadle and Christianson (1988) noted that 75% of all HMOs that were less than three years old were for-profit enterprises.

HMOs and cost containment

The second major trend in HMOs is a byproduct of the new emphasis on profits. As profits increase in importance, HMOs have been forced to find new ways of

containing costs. Originally, HMOs sought to control costs by providing preventive health care. Over time, HMOs moved away from preventive care, because it was no longer cost effective for the insurer. Preventive care requires a capital investment, which may not be realized if the individual moves to another part of the country, or to another health care system (Bloom, 1990). Currently, HMOs attempt to cut costs not through preventive care, but by restricting access to hospitalization, and by reducing the length of hospital stays (Flinn, McMahon, & Collins, 1987). In practice, these are the two basic strategies of managed care.

Managed Care

Historical Background

According to Bloom (1990), managed care was virtually unheard of in 1975. The rise of managed care over the last twenty years can be traced to a series of financial pressures that faced the health care industry in the 1980's. Initially, the federal government tried to contain health care costs by promoting HMOs as an alternative health care system. In addition to subsidizing HMOs, the federal government also developed a reimbursement system to limit the costs of providing services. The system consisted of prospective fixed payments for diagnosis-related groups of illnesses (DRG's). In effect, the DRG's worked as a ceiling: treatment procedures would only be reimbursed at a specified rate. DRG's were very successful at containing costs, and eventually became an industry standard, used by both insurers and HMOs.

As a result of the use of DRG's, hospitals began to lose revenue. To make up for that lost revenue, many hospitals opened inpatient psychiatric or substance abuse treatment facilities. This solution appealed to many institutions, because alcohol, drug, and mental health (ADM) charges were exempted from DRG regulations (Broskowski, 1991). The strategy worked in the short term, as ADM treatment brought in needed income.

By the end of the 1980's, the costs of providing mental health care had climbed dramatically. In 1988 alone, utilization of inpatient psychiatric hospital facilities rose 37%. Overall, between 1988 and 1991, mental health care expenditures increased at a rate of 41% per year (Cummings, 1992). As mental health care utilization costs skyrocketed, many HMOs and third party payors perceived that providers were acting out of their own financial self-interest, and abusing patient health care benefits through overutilization of unnecessary services (DeLeon, VandenBos, & Bulatao, 1991). Insurers and HMOs were once again forced to develop a new way of cutting costs.

Case management, or managed care as it came to be known, represented a new approach. Traditional insurance plans attempted to save costs by limiting care, primarily through altering the design of their health care benefit package. Under this strategy, the cost of providing health care is limited to specific dollar amounts, either through annual or lifetime caps, or through the use of DRG's (Dworkin & Hirsch, 1994). While many managed mental health care organizations (MMHCOs) also rely

on benefit design to limit care and thereby reduce costs, managed care is based on a different principle: the direct intervention of a representative of the payor in the provision of health care services. Using protocols or their own judgment, case managers make decisions about what types of care, if any, will be reimbursed, and at what rate.

Managed care is currently the primary means used to control health care costs (Lowman, 1991; Newman & Bricklin, 1990). By 1991, less than three years after it was introduced, over 70% of inpatient psychiatric care was delivered in managed care systems, and over 30% of all employers used special managed mental health care networks (England & Vaccaro, 1991). Cummings (1992) reported that managed care was growing at a rate of 25% per year, and that over 52 million Americans were receiving their health care from managed care systems.

The benefits of managed care are not limited to its potential to cut costs. Many professionals believe that managed care patients receive better health care than those individuals who are involved with more traditional delivery systems. England and Vaccaro (1991) outlined some of the advantages of managed care. They noted that fee-for-service plans often resulted in overuse of hospitalization. As a result, many health care purchasers came to believe that psychiatrists were operating in their own self-interest. Managed care systems have sought to restore purchaser confidence by reducing unnecessary hospitalization, and referring patients to less costly but equally effective treatment alternatives. Instead of limiting benefits to inpatient hospitalization,

clinicians can choose the appropriate level of treatment from a wide variety of options, including partial hospitalization, residential care, and day or evening treatment programs.

England and Vaccaro also observed that insurers and third party payors often purchased mental health care services without knowing what constituted effective clinical care. Without accurate information, purchasers could not be sure that their clients were receiving quality care from competent mental health care professionals. Managed care companies have attempted to improve patient care by developing protocols that match specific patient problems with appropriate clinical interventions, and by mandating specific minimum levels of credentials for approved providers (England and Vaccaro, 1991).

Panzarino and Wetherbee (1990) argued that case management can result in a more effective integration of services. Case managers are involved with a referral from the time of the initial complaint. After making an referral to the appropriate level of care, the case manager maintains contact with the provider, and monitors the patient's progress. After each phase of treatment, the case manager continues to coordinate mental health services, making sure that the patient receives referrals for the appropriate level of aftercare.

Managed Care Strategies

Reducing the Cost of Services

Managed care systems use two basic approaches to containing costs: reducing the cost of services, and reducing utilization of those services. Managed care companies save money by negotiating fee-for-service contracts with a group of preferred providers, who agree to discount their services in return for a steady source of referrals (Broskowski, 1991). Under the prevailing industry standard, third party payors reimburse providers for 50% of their fee - that is, if a psychologist charges $80 per hour, the third party pays $40 (Zimet, 1989). In addition, virtually all HMOs and MMHCOs reduce the price of services by using prospective fixed payments for diagnostic-related groups (DRG's). Finally, managed care companies often lower the price of services through the process of claims review, in which services that have already been delivered are subject to re-examination (Broskowski, 1991).

HMOs also attempt to reduce the cost of services by providing a limited range of benefits to a clearly defined set of covered individuals (Haas & Cummings, 1991). Using this approach, HMOs and managed care systems offer coverage for less expensive, but equally effective, treatment alternatives. For example, most third party payors now refer substance abuse patients to a hospital for a 5 day inpatient detoxification, followed by outpatient treatment, as opposed to a 28 day inpatient stay (Broskowski, 1991).

Reducing the Utilization of Services

Managed care systems and HMOs have developed a variety of ways to save costs by reducing the amount of services used by beneficiaries. These mechanisms include pre-treatment authorization, benefit plan design, session limits, and utilization review. According to Panzarino and Wetherbee (1990), "taken separately, each step can be an effective tool for decreasing utilization".

Limiting access to treatment

Limiting access to treatment is the primary cost cutting strategy used by managed care systems (Haas & Cummings, 1991; Hannigan-Farley, 1992). Most MMHCOs and HMOs require patients to obtain pre-treatment authorization before they receive services (Dworkin & Hirsch, 1994). Shadle and Christianson (1988) reported that 75% of HMOs require a referral from a primary care physician, or "gatekeeper", for mental health care. In particular, managed care systems rely on prospective control systems to regulate patient access to inpatient treatment (Lowman, 1991; Panzarino & Wetherbee, 1990).

Many HMOs and MMHCOs also rely on benefit plan design to limit access to treatment. Benefit plan strategies for limiting access include diagnostic exclusions, copayments and deductibles, and the use of preferred providers.

Patients who have chronic mental illness consume 43% of the total cost of direct mental health care. As a result, many managed care companies attempt to reduce their financial exposure through the use of diagnostic exclusions, which

prevent those patients from entering the health care system (Haas & Cummings, 1991). In addition to diagnostic exclusions, HMOs and managed care systems rely on deductibles and copayments to limit patient access to treatment. Finally, most HMOs and MMHCOs attempt to limit access by providing financial incentives or constraints to receive services from a specified set of preferred providers, who are selected on the basis of their efficiency (Dworkin & Hirsch, 1994; Panzarino & Wetherbee, 1990; Richardson & Austad, 1991).

Limiting treatment

Limiting the type or amount of treatment that a patient can receive is another way of reducing utilization of services. Most HMOs and managed care systems rely on concurrent utilization review to limit patient care (Dworkin & Hirsch, 1994; Panzarino & Wetherbee, 1990). In concurrent utilization review, case managers monitor a patient's progress through periodic reports by the provider. After a pre-determined number of sessions, the provider applies to the managed care system for re-authorization. The case manager will examine the report using a set of criteria, and make a decision regarding the patient's treatment. If the case manager concludes that the patient is not benefiting from treatment, or that the provider is not using an effective treatment plan, additional sessions will not be granted, thereby limiting treatment.

Almost all HMOs and managed care systems use session limits as a means of reducing the utilization of services. The HMO Act of 1973 required HMOs to provide

a minimum mental health benefit of 20 sessions per year of outpatient psychotherapy (Newman & Bricklin, 1990). According to Richardson and Austad (1991), that requirement has become the industry standard: 79% of all HMOs employ a 20 session limit.

Problems with Managed Care

Conflicts of Interest

Many fundamental problems associated with managed care stem from the nature of HMOs, and how they differ from indemnity insurance plans. In traditional indemnity plans, the financial risk is spread among the insured. If expenditures exceed premiums, rates can be raised to cover the shortfall. HMOs differ in that they have contractual relationships with purchasers, and therefore take a direct financial risk: they stand to lose substantial amounts of money, because their income is limited for the duration of the contract. Because they take a financial risk, HMOs have a natural incentive to contain costs (Flinn, McMahon, & Collins, 1987). As a result, the profitability of HMOs often hinges on providing only those services which are absolutely necessary (Bloom, 1990; DeLeon, VandenBos, & Bulatao, 1991).

This situation gives rise to the key issue in medicine today: who defines what is necessary? Currently, that determination is made by third party payors and managed care systems. This practice creates an unavoidable conflict of interest (Berman, 1992), and raises questions about how third party payors can remain impartial when they

stand to profit through underserving the needs of their clients (Kiesler & Morton, 1988).

The evidence suggests that most HMOs find it difficult to maintain impartiality. Levin (1988) compared service utilization in for-profit and not-for-profit HMOs. The results of the study revealed a significant difference in two areas: non-profit HMOs had higher mean annual hospital utilization rates, as well as longer patient stays.

Limiting Access to Treatment

Many HMOs and MMHCOs attempt to contain costs by limiting access to treatment (Haas & Cummings, 1991; Hannigan-Farley, 1992). Miller (1992) studied access to treatment in both HMO and fee-for-service arrangements. The results showed that fee-for-service plans offered increased access to treatment, and that HMOs were associated with a decrease in patient access to medical care.

Gatekeepers

For most patients, restricting access poses the greatest threat to the quality of care that they receive (Panzarino & Wetherbee, 1990). Often, the required pre-treatment authorization by a gatekeeper results in the patient being denied adequate care (DeLeon, VandenBos, & Bulatao, 1991). Wells led a team that examined the use of primary care physicians as gatekeepers for mental health referrals (Wells, Hays, Burnam, Rogers, Greenfield, & Ware, 1989). The authors tracked depressed patients in both fee-for-service and pre-paid settings. In the fee-for-service plans, depressed patients were interviewed by mental health professionals, while in the pre-paid plans,

patients went to primary care physicians, who acted as gatekeepers for further referrals. After their office visits, patients in both groups filled out a depression screening instrument. Patients who exceeded the cut-off score for the screening measure were administered the depression section of the Diagnostic Interview Schedule, which provided an independent assessment of the presence of depression. The authors found that the method of payment had a significant influence on the ability of the provider to identify the presenting problem: 86% of the patients who consulted a mental health provider had their depression detected, compared to only 51% of those who visited primary care physicians.

Benefit plan design

Benefit plan design is another strategy HMOs and managed care systems use to control costs. According to Miller, (1992) benefit design often discriminates against individuals who come from lower socio-economic classes, especially when the benefit package requires enrollees to cover a deductible or to make a copayment. For those who cannot afford them, deductibles and copays serve as effective barrier to treatment (Kisch & Austad, 1988).

In addition, most HMOs and MMHCOs use diagnostic exclusions to discriminate against patients with specific diagnoses. Evidently the practice is widespread: Lange, Chandler-Guy, Forti, Foster-Mooge, and Rohman (1988) found that 46% of the HMOs in their study used exclusionary criteria. In particular, insurers discriminate against patients who have histories of drug or alcohol abuse, as well as

borderline or multiple personality disorder (Dorwart, 1990). Insurers have also developed a complement to diagnostic exclusions, called "skimming" (Haas and Cummings, 1991), which involves the use of specific criteria to select enrollees who will be less likely to use health care services.

Limiting Treatment

Restricted levels of care

According to Miller (1992), managed care restrictions on levels of care can prevent patients from having access to appropriate treatment. Many HMOs attempt to prevent hospitalization through use of crisis intervention services and alternative holding environments (Austad, DeStafano, & Kisch, 1988). Shadle and Christianson (1989) noted that inpatient days had dropped 82% in the twelve year period between 1975 and 1987. The authors reported that HMOs hospitalize patients at less than half the rate of the community as a whole, and concluded from the evidence that HMOs discourage the use of inpatient treatment. This trend is especially strong in group HMOs, where the increased financial risk provides an extra incentive to avoid patient hospitalization (Austad & Sherman, 1992).

Session limits

Originally, HMOs were required to offer a minimum mental health benefit of 20 outpatient psychotherapy sessions as a prerequisite for receiving federal subsidies. Richardson and Austad (1991) have observed that for most HMOs and third party payors, minimum coverages have become maximum benefits. According to DeLeon,

VandenBos, and Bulatao (1991), most benefit packages are not designed to provide ongoing mental health care, which can create a dilemma for practitioners with patients who have exhausted their benefits (Strom, 1992). Under the APA Code of Ethics, psychologists cannot abandon their patients, yet as patients exhaust their benefits, providers can be faced with a growing portion of their caseload that is served on a *pro bono* basis. Many practitioners must now choose between abandoning their patients or going bankrupt (Cummings, 1986).

Rather than make provisions for continuing care for patients who have exhausted their benefits, many HMOs and MMHCOs refer their chronic mentally ill patients to public mental health facilities (Berman, 1992; Haas & Cummings, 1991). Shadle and Christianson reported that in one Midwest HMO, 66% of all child psychiatric hospitalizations were eventually transferred to publicly funded facilities. The problem of patient dumping has been exacerbated by cuts in federal mental health care budgets, leading some practitioners to wonder where patients will be transferred to when publicly funded facilities close (Levin, 1988).

Limiting treatment modalities

Some HMOs and MMHCOs cut costs by placing limits on the type of treatment that a patient can receive (Steefel, 1992). In practice, this restriction is achieved by only reimbursing a specific range of interventions, selected from a limited constellation of theoretical orientations (Haas & Cummings, 1991). For example, most MMHCOs favor the use of short-term behavioral, crisis, or problem solving therapy (Austad,

DeStafano, & Kisch, 1988). In addition, some insurers enforce limits on the type of treatment by restricting modalities. Patients at Kaiser Permanente, a large HMO, receive group therapy, regardless of the presenting problem (Wright, 1992).

Quality of Care

For many patients, negotiating their way through gatekeepers and benefit package restrictions makes gaining access to appropriate treatment a difficult process. Once they have been authorized to receive services, many patients are faced with a separate set of problems. According to Newman and Bricklin (1990), "the greatest focus of concern stimulated by managed care has been the potential adverse impact of financial incentives on the quality of care provided."(p. 26).

To substantiate their claim, the authors noted that 86% of mental health care professionals believe that the quality of patient care suffers when services are delivered through managed care systems. Miller (1992) also found that psychologists associate HMOs with a decrease in the quality of care. Finally, Lange et al. (1988) asked providers to rate the quality of HMO mental health services. The results revealed that a substantial portion of the respondents felt that HMOs offered substandard care.

Most HMOs and MMHCOs use preferred providers as a means of cutting costs. Ostensibly, using preferred providers allows third party payors to reduce expenditures by negotiating fees with highly skilled practitioners who are selected on the basis of their effectiveness and efficiency. In practice, referring patients to preferred providers often means that patients receive their care from staff who have fewer credentials

(Austad, DeStafano, & Kisch, 1988; Bloom, 1990; Cummings, 1986; Cummings, 1988; Flinn, McMahon, & Collins, 1987). In a survey of over 30 HMOs, Lange et al. (1988) found that less than half of the mental health care providers had a doctoral degree.

The erosion of professional standards represents an additional threat to the quality of patient care (Chipman, 1994). The CAPP study (APA, 1996) revealed that exclusion from panels remains one of the most pressing concerns among psychologists. The difficulty that most practitioners face in getting on provider panels makes staying on them even more important. Without the income generated by referrals from managed care sources, practitioners who are dropped from provider panels may be faced with financial disaster. As a result, managed care systems can exert enormous financial pressure on practitioners to acquiesce to a case manager's treatment decisions. Psychologists who insist on appropriate mental health services for their patients risk being removed from provider panels, because they are not "managed care compatible". This difficult situation is exacerbated by clauses in managed care contracts that allow payors to terminate psychologists from panels "without cause" (APA Monitor, July 1996).

Many practitioners avoid being removed from provider panels by adopting the system standards in place of professional ones. This shift in the standard of care can have a significant impact on the quality and amount of treatment that a patient receives. Austad, DeStefano, and Kisch (1988) state, "the HMO practitioner values

minimalist therapeutic intervention" (p. 450). The authors expand on this premise, and provide a rationalization for minimal care in HMOs:

> For some therapeutic tasks to be accomplished, the therapist does not even have to meet with the patient to have an impact. Many patients claim that they are helped just by knowing that, if at crucial times in their lives, they were to call, there does exist someone who knows and understands their problems. This information is often as much comfort as the patient needs, and ironically enough, serves as a deterrent to actual contact (p. 454).

Utilization Review

Background

Utilization review (UR) is one of the core technologies of managed care (England & Vaccaro, 1991). According to Tischler (1990), more than 60% of Americans with group health insurance receive health care from managed care systems that employ utilization review. When it was first developed, utilization review was a retrospective procedure, analogous to quality assurance (Tischler, 1990). The goal of utilization review was ensure that patients obtained the appropriate level, modality, and type of treatment (Blackwell, Gutmann, & Gutmann, 1988; Lowman, 1991).

Over time, the nature of UR has changed, in response to profit-making pressures. The primary emphasis is now on cost containment, and utilization review has shifted from a retrospective process to a prospective procedure (Lowman, 1991; Sharfstein, 1990). Currently, utilization review is defined as:

> A set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision making through case by case assessment of the appropriateness of care prior to its provision. (Institute of Medicine, 1989, in Sharfstein, 1990, p. 965).

Procedure

In utilization review, case managers make decisions by comparing documentation submitted by providers to a pre-established set of criteria (Tischler, 1990). Before they authorize treatment, managers consider patient diagnoses, as well as provider treatment and aftercare plans. In addition to approving treatment, case managers make a number of other decisions. Upon review, a manager may decide to deny coverage for a mental illness, on the basis of an exclusionary diagnosis. Similarly, a manager may disapprove a request for inpatient hospitalization, and recommend that a patient be referred to a lower level alternative. Finally, a manager may decide to terminate a patient's treatment, on the grounds that it is no longer warranted by medical necessity.

Problems with Utilization Review

Quality of Care

Hoyt (1992a) observed that there is a difference between quality assurance, which is devoted to evaluating the care a patient receives, and utilization review, which is concerned with containing costs. Sharfstein (1990) reported on the results of an extensive study commissioned by the Institute of Medicine, which investigated the

impact of utilization review on the quality of patient care. The study found that there was no evidence that supported the use of utilization review as a means of ensuring that patients receive appropriate care. Tischler (1990) concurred, noting that research has only addressed the effectiveness of utilization review in reducing the length of inpatient hospitalization, and that there has been no documentation of the appropriateness, adequacy, or effectiveness of utilization review treatment decisions.

However, part of the difficulty in assessing the impact of managed care and utilization review on the quality of care comes from a lack of clear standards. The absence of any clear definition of quality care has prevented researchers from developing any objective measures of quality care. Without any objective criterion, discussions of the impact of utilization review on the quality of care remain speculative.

Lack of Cost Effectiveness

During the 1980's, hospitals turned to mental health care as a way of making up revenue lost to DRG's. As more and more patients used inpatient psychiatric or ADM services, mental health care costs rose from 4% to more than 11% of total medical expenditures. Of particular concern to insurers was the large proportion of total mental health expenditures that was devoted to treating the small percentage of patients who used a disproportionate amount of services. According to Zook and Moore (1980), half of all health care resources are consumed by high cost users, who constitute only 13% of the population. Utilization review was designed to contain the

financial risk associated with providing services to those chronic or severely distressed patients.

The application of utilization review procedures in outpatient settings is based on the premise that outpatient mental health care patients tend to overuse services. Consequently, the profitability of utilization review lies in the difference between the cost of performing utilization review and the savings that accrue from preventing the overuse of services.

Using data gathered by the APA (1994), Michaelson (1993) came to the conclusion that utilization review was not cost effective in outpatient settings. According to the National Medical Care Utilization and Expenditure Study, mental health patients comprise only 4.3 % of the total amount of medical care users in 1984 (Taube, Goldman, Burns, & Kessler, 1988). Contrary to the expectation that mental health care patients tend to overuse services, the median number of therapy sessions was two. Kisch (1992) also provided evidence that most patients use mental health care conservatively, noting that only 38% of the patients in his study used more than five therapy sessions, and that only 4.3% used more than 30 sessions. Because high psychological service utilization is not widespread, even in the absence of case management, utilization review has not proved to be cost effective.

Blackwell, Gutmann, and Gutmann (1988) also studied outpatient psychological service utilization rates, comparing patients in a pre-paid plan that employed utilization review with patients in a fee-for-service plan that offered

unlimited access to treatment. The authors reported that fee-for-service and pre-paid patients did not differ in service utilization. In both groups, patients had an average of six sessions, and 78% of the patients completed treatment within eight sessions. The modal amount of sessions was one.

A substantial body of research suggests that utilization review is not cost effective. Dorwart (1990) reviewed the literature, and found that utilization review resulted in a one-time savings at implementation, but that it was not cost effective on a continuing basis. Rather than being an effective means of containing costs, utilization review has created a downward spiral in service provision. In order to offset the increased overhead associated with utilization review, many managed care systems are having to scale back mental health care services even further (Sharfstein, 1990).

Conflict of Interest

Newman and Bricklin (1990) noted that in utilization review, as with managed care in general, there is a tension between the profit motive and providing adequate care. In utilization review, this tension is crystallized in a conflict of interest, between evaluating the need for psychological services and making a profit by decreasing the utilization of those services (Wright, 1992). If a managed care system is to remain profitable, administrators cannot afford to hire or maintain case managers who are not cost effective (Berkman, Bassos, & Post, 1988). Because their job security often hinges on cost cutting, case managers can experience a considerable amount of difficulty in separating self-interest from the best interests of the patient (Patterson, 1990).

Lack of Clear Criteria

The absence of clear and consistent policies or criteria for making treatment decisions frustrates many practitioners in their attempts to secure appropriate treatment for their patients. England and Vaccaro noted that 45% of the psychiatric hospitals surveyed complained that utilization review criteria were often ambiguous. Some managed care companies simply refuse to reveal the criteria that they use in their decision-making (Tischler, 1990).

A second problem with utilization review criteria stems from the use of a specific criterion - "medical necessity" - which often acts as a barrier to treatment (Berman, 1992; Sinnett & Holen, 1993). Even though the medical necessity for most outpatient treatment has never been established, medical necessity remains the central criterion used in utilization review decision-making related both to initial patient access to services and the continuation of ongoing outpatient treatment (Zimet, 1989).

Chipman (1994) noted that the medical necessity is increasingly defined in functional terms. According to Berman (1992), functional necessity refers to "biopsychosocial interventions that are necessary and sufficient to help an individual cope more effectively with a difficult situation, or alleviate a state of acute distress" (p. 40). While this definition clarifies what constitutes functional necessity, it leaves open the question of which party determines when the patient has been restored to a suitable level of functionality.

Ethical Conflicts

Dealing with utilization review often means that practitioners must negotiate a new set of ethical challenges, especially in the areas of diagnosis and patient confidentiality. Because diagnostic exclusions do not cover certain conditions, many providers misdiagnose patients deliberately in order to obtain reimbursement. In a survey of clinical social workers, Strom (1994) found that 37% of the providers reported giving a more severe diagnosis in order to obtain reimbursement, and that 57% had reported treatment falsely (e.g., indicating that individual treatment had been delivered instead of family therapy). Kirk and Kutchins (1988) also reported epidemic rates of misdiagnosis. In their study of social workers, 72% of those surveyed indicated that they had used a more severe diagnosis to obtain reimbursement for a patient, and 56% had used an Axis 1 diagnosis of a major mental disorder.

Problems with utilization review and patient confidentiality have led to an increasingly public debate about the privacy of medical records (Lewin, 1996; Scarf, 1996). A study of Kansas psychiatrists found that most practitioners believed that utilization review had a great potential for compromising patient confidentiality (Sinnett & Holen, 1993). While some managed care companies respond that patient confidentiality is no longer possible (Dworkin & Hirsch, 1994), almost half of the HMOs surveyed by Shadle and Christianson (1988) saw a need for improvement in their own procedures in handling patient records. For some patients, the lack of

confidentiality in managed care settings is a key factor in their decision to terminate treatment (Patterson, 1990).

Utilization Review and Psychologists

Most psychologists have grave concerns about the role of managed care and utilization review in changing clinical practice (APA, 1996). In particular, practitioners have expressed reservations about the potential for utilization review to influence the clinical decision-making process (Barnett, 1993). Zuckerman (1989) noted that the nature of utilization review has changed, from a retrospective process to a prospective procedure, as managed care systems began to require pre-authorization for mental health care. According to Zuckerman, when utilization review becomes prospective, it exerts a direct control over treatment. Sharfstein (1990) concurred, calling utilization review "the most explicit and direct effort to regulate and control physicians by modifying their decisions" (p. 965). In fact, in a study commissioned by the American Psychiatric Association, 60% of the psychiatrists surveyed indicate that they had been discouraged by utilization reviewers from hospitalizing patients, or pressured to shorten inpatient stays.

As utilization review is becoming a central force in clinical decision-making, many providers are experiencing an increasing degree of discomfort. Michaelson (1993) commented that utilization review entails "asking a person, sight unseen, to make a life and death decision about a patient that you have a relationship with" (p. 23). Adding to this discomfort is a sense of frustration regarding the personnel who are

involved in utilization review. Most often, case managers and utilization reviewers are social workers and registered nurses (Panzarino & Wetherbee, 1990; Tischler, 1990), creating a situation where many psychiatrists view utilization review as "social workers are telling physicians what to do" (Shadle & Christianson, 1989, p. 1149). For many practitioners, utilization review has reduced professional practitioners to the role of technicians carrying out the directives of managed care staff (Berkman, Bassos & Post, 1988; Strom, 1992b; Weimer, 1990).

Career Satisfaction

HMOs and Career Satisfaction

Theoretical Foundation

Managed care has brought a great deal of change to the practice of psychology. How is this change related to career satisfaction among practitioners? Dawis, England, & Lofquist's Theory of Work Adjustment (1964, can provide a conceptual framework for investigating the role of managed care in career satisfaction among psychologists.

Work Adjustment Theory is a person-environment interaction approach to career satisfaction. The theory combines elements of learning theory - stimulus, response, and reinforcement - with a traditional matching model derived from the work of Frank Parsons, in which career satisfaction is considered to be the result of matching individuals with environments that fit their interests, skills, or personalities. According to Work Adjustment Theory, as workers' personalities vary, so do their respective needs. Similarly, work environments differ in the type and degree of

reinforcers present: each work environment is defined by a specific set of reinforcers. Career satisfaction is the result of a correspondence - or "match" - between the worker's needs and the capacity of the work environment to meet those needs. Dawis, Lofquist, and Weiss (1968) note that although work-related needs remain relatively stable over the adult lifespan, career satisfaction can fluctuate with changes in the work environment.

The Theory of Work Adjustment has received a considerable amount of empirical support. Tziner (1983) examined the relationship between career satisfaction and correspondence between worker needs and occupational reinforcers. The results of the study showed that career satisfaction and correspondence between individual needs and occupational reinforcers were strongly related: the higher the level of correspondence, the greater the individual satisfaction.

Rounds (1990) evaluated need/reinforcer correspondence as a predictor of career satisfaction, and compared the effectiveness of the Work Adjustment model with Holland's theory of vocational interest congruency. Both Work Adjustment Theory and Holland's interest congruency are matching models, and both posit career satisfaction is a function of the fit between worker characteristics and features of the occupational environment. The theories differ in their description of the critical predictor variable: Work Adjustment Theory focuses on the fit between worker needs and occupational reinforcers, whereas Holland emphasizes the relationship between individual interests and characteristics of the work environment.

Rounds found that work values or needs made a significant contribution to the prediction of career satisfaction, after controlling for interest congruency. Worker needs accounted for 29% of the variance in career satisfaction, compared to only 4% contributed by interest congruence. In addition, the results gave strong support to the hypothesis that interest congruency and needs correspondence are two separate and unrelated constructs.

After initial research supported the validity of the needs/reinforcer model, Rounds, Dawis, and Lofquist (1987) studied the relative contributions of occupational reinforcer patterns (ORPs) and worker needs to career satisfaction. The researchers used the Minnesota Importance Questionnaire to assess individual needs, and the Minnesota Job Description Questionnaire to define occupational reinforcers. Once again, the authors found that there was a moderate to strong relationship between need/reinforcer correspondence and career satisfaction. Overall, occupational reinforcers were more effective in predicting career satisfaction than individual needs.

Rounds and his colleagues examined the construct of occupational reinforcers in depth, in an attempt to identify the critical aspects of reinforcement. Occupational reinforcers patterns were assessed along three dimensions: reinforcer elevation, a measure of the strength of a specific reinforcer; scatter; and profile shape, which captured the presence, rather than the degree, of the reinforcer. Multiple regression analysis revealed that profile shape proved to be the most effective predictor of career satisfaction.

A number of studies have examined the underlying factor structure of worker needs and occupational reinforcers. Lofquist and Dawis (1978) performed a factor analysis on the Minnesota Importance Questionnaire, a measure of worker values or needs. The authors derived six value dimensions. The first factor was termed Achievement, and consisted of ability utilization and achievement. The Comfort value dimension was comprised of compensation, working conditions, activity, security, and variety. The third factor was defined as Status, and was composed of advancement, recognition, authority, and social status. Altruism was the fourth factor, and contained elements of moral values, social service, and values related to co-workers. The fifth factor was termed Safety, and was composed of company policies and practices, supervision in human relations, and technical supervision. Autonomy was the last factor, and included both creativity and responsibility. The authors also divided individual needs into three separate categories: preferences related to the external environment; reinforcement from other people; and self-reinforcement, which included the need for achievement and autonomy.

Macnab and Fitzsimmons (1987) used a multitrait-multimethod analysis to investigate the relationship between needs, work values, and preferences. Confirmatory factor analysis of the multitrait-multimethod matrix revealed an 8 factor structure of work values or needs: authority, coworkers, creativity, independence, security, altruism, work conditions, and prestige. Pryor (1987) also examined the underlying structure of work values, using the Work Aspect Preference Scale. Analysis

of the data supported a three factor solution to describe work values. The first factor was termed Non-work Orientation, and was composed of lifestyle, money, and detachment. Pryor described this factor as the individual's concern "that work not interfere with the rest of one's life". (p. 427). The second factor was termed Freedom, and contained elements of creativity, self-development, and independence. Pryor defined the Freedom factor as "indicating a personal commitment to work in which the person exercises prerogative and initiates rather than follows, innovates rather than implements". (p. 428). The final factor was described as Human/Personal Concern, and was composed of altruism, coworkers, and security. The results supported Lofquist & Dawis' (1978) taxonomy, which separated needs into three distinct groups: environmental reinforcers, reinforcement from other people, and self-reinforcers.

Finally, Doering, Rhodes, and Kaspin investigated the factor structure of both individual needs and occupational reinforcers. The authors found a three factor solution for both constructs. For worker needs, the first factor was composed of autonomy and achievement; the second factor grouped compensation, recognition, and social status, and the third factor contained the elements supervision/human relations and company policies and practices. Occupational reinforcers were also grouped into three underlying factors. The first factor was described as self-reinforcement, and contained ability utilization, creativity, achievement, recognition. The second factor was composed of reinforcers that were derived from the organizational environment, and was comprised of supervision/human relations and

company policies and practices. The last factor was termed "working alone" and was composed of independence and autonomy. According to the authors, "Given that autonomy was reinforced, it follows that individuals would perceive that working alone is important in achieving, using their abilities, and expressing creativity." (p. 137).

Overall, research has supported Lofquist and Dawis' original model of needs and reinforcers. Lofquist and Dawis have continued their investigation into occupational reinforcer patterns (Stewart, Greenstein, Holt, Henly, Engdahl, Dawis, Lofquist, & Weiss, 1986). The team assembled a index of 187 occupational reinforcer patterns, including profiles of both clinical and counseling psychology. The two disciplines shared an identical pattern, with achievement, altruism, and autonomy being the key reinforcers.

In the Lofquist and Dawis model, the achievement reinforcer is composed of ability utilization, defined as the opportunity for individuals to use their abilities, and achievement, or the ability to obtain a feeling of accomplishment. The altruism reinforcer captures three areas: the degree to which an individual has coworkers who are easy to make friends with; social service, or the opportunity to benefit other people; and moral values, which is defined by an environment that allows workers to perform their duties without feeling that they are morally wrong. The final reinforcer is autonomy, which is composed of creativity, or the opportunity for workers to try out their own ideas; responsibility, which is defined as the chance for workers to make

decisions on their own; and autonomy, or the workers' ability to plan their work activities with little supervision.

Historically, achievement, altruism, and autonomy have been the key reinforcers for psychologists. Recent changes brought about by managed care have had an enormous impact on the reinforcement structure of the mental health care professions. Practitioners no longer enjoy the same degree of independence and influence over clinical decisions, and many professionals have complained that working with managed care or utilization review entails unavoidable ethical conflicts. According to Work Adjustment Theory, these changes in the reinforcement structure of psychology would suggest that career satisfaction among psychologists has also changed.

HMOs and Career Satisfaction

Baker and Cantor (1993) supplied evidence that supported a connection between managed care and career satisfaction. They surveyed a group of HMO and self-employed physicians, and found that HMO physicians were significantly less satisfied with their practice than self-employed doctors. The HMO physicians were also significantly less satisfied with their income. The authors also found that perceived clinical freedom was associated with a number of satisfaction indices. HMO physicians reported that managed care exerted its strongest negative influence on their autonomy in the areas of patient selection and time management. Similarly, self-employed physicians with managed care contracts were also less likely to feel able to spend an

appropriate amount of time with patients. Baker and Cantor found a negative correlation between managed care and perceived autonomy: as involvement with managed care rose, physicians were less likely to perceive that they were able to control their time.

HMOs and Burnout

A team of researchers led by Snibbe investigated burnout among psychiatrists, primary care physicians, and social workers in an HMO setting (Snibbe, Radcliffe, Weisberger, Richards, & Kelly, 1989). The Maslach Burnout Inventory was used to assess burnout along three dimensions: emotional exhaustion, depersonalization, and sense of personal achievement. For the purposes of their study, the authors defined depersonalization as "an unfeeling and impersonal response towards recipients of one's care or service" (p. 776).

The results showed that that the psychiatry group suffered from a very high level of burnout. In particular, HMO psychiatrists had significantly higher levels of emotional exhaustion than the normative sample for the Maslach Burnout Inventory. The authors drew a number of conclusions from the evidence. First, the authors found that burnout was associated with job dissatisfaction. Secondly, the researchers felt that assembly-line treatment was harmful to the providers: practitioners need to have a sense of accomplishment. Finally, the authors observed that mental health care providers work best when they feel some measure of control over their work environment.

Austad, Morgan, and Holstein (1992) surveyed practitioners who were salaried employees in 10 separate staff model HMOs in New England. The participants offered a number of suggestions on avoiding burnout to psychologists who might be considering accepting a position in a staff model HMO. The majority recommended limiting the length of employment to two to three years as the best way of avoiding burnout. DeStefano (1992) also observed that long term work in an HMO setting inevitably leads to feelings of burnout. DeStefano followed with a list of the three primary causes of burnout for psychologists in HMO settings: 1) on-call systems; 2) a perceived lack of control over patients caseloads; and 3) managed care policies of not hospitalizing patients unless they are in imminent danger of harming themselves or others.

Managed Care and Career Satisfaction

McKelvey and Webb (1995) examined the links between managed care and career satisfaction in a group of Houston-area psychiatrists. The majority of the psychiatrists in the study listed managed care and changes in third party payments as the leading threat to the quality of psychiatric care. The results also showed that psychiatrists in private practice had the lowest level of career satisfaction, and were the most pessimistic about the potential for positive change in their professional field. McKelvey and Webb listed four factors that were associated with career satisfaction among psychiatrists: 1) the quality of patient care; 2) the financial rewards of practice; 3) the type of patients in the caseload; and 4) the work environment. Overall, the

source and the amount of physician income had the strongest univariate correlations to career satisfaction.

Managed Care and Burnout

Levant (1994) reported on a survey that had been conducted under the auspices of the Oregon Psychological Association. The results of the study showed that levels of practitioner burnout rose as a function of increased managed care market penetration. Analysis of the data led to a list of five factors which are associated with burnout among mental health service providers: 1) lack of control over treatment decisions; 2) an increase in conflicts of interest; 3) an increase in practitioner workload; 4) negative practitioner perceptions of workload; and 5) an increase in work-related stress.

A number of other authors have commented on negative aspects of managed care settings that have an impact on burnout and career satisfaction. Hoyt (1992b) and Henault (1992) cited overwork as a primary correlate of burnout. Hoyt identified three additional sources of burnout in managed care settings: limited treatment goals; pressures to undertreat patients; and threats to patient confidentiality.

Summary

Though research in the allied mental health professions suggests that managed care has a negative influence on career satisfaction, there is no information on the impact of managed care on career satisfaction among psychologists. This study will be concerned with the following two research questions: 1) what is the level of career

satisfaction among psychologists who are engaged in delivering psychological services? and 2) what is the relationship between managed care and career satisfaction among psychologists?

CHAPTER 2

METHODOLOGY

Hypotheses

This study will test the following set of four alternative hypotheses:

H_1 #1: Psychologists' career satisfaction will vary as a function of the percentage of practitioners' caseload that is under managed care.

H_1 #2: Among licensed psychologists, intrinsic career satisfaction will be greater than extrinsic career satisfaction.

H_1 #3: Among licensed psychologists, career satisfaction will vary as a function of their demographic characteristics.

H_1 #4: Among licensed psychologists, career satisfaction will vary as a function of variables that represent managed care business practices, managed care communications, and practitioners' experience of ethical dilemmas associated with third party payors and managed care.

Subjects

The participants in the study were licensed doctoral level psychologists who spent at least twenty five hours per week providing direct psychological services. The Research Office of the APA provided a random sample from its membership of over 62,000 psychologists, and generated a subject pool that matched the desired sample size and target population of the study.

The planned data analysis required a minimum of 150 complete data sets. The return rate of 30% in the APA CAPP study provided the guideline for the determination of the sample size for this study, which used a pool of 700 practitioners to generate a sufficient amount of participants for data analysis. Research subjects were not remunerated or offered incentives to participate.

Instrumentation

Career Satisfaction

This study used the short form of the Minnesota Satisfaction Questionnaire (MSQ; Weiss, Dawis, England, & Lofquist, 1967) to assess career satisfaction. According to Weiss, Dawis, England, & Lofquist, the MSQ "measures satisfaction with several specific aspects of work and work environments" (p. vi), and provides a more detailed representation of worker satisfaction than a global assessment of satisfaction with a career as a whole. The short form of the MSQ is a self-report questionnaire containing 20 items. Responses are based on a 5-point Likert scale. The manual for the MSQ indicates that completing the short form should require no more than ten minutes (Weiss et al., 1967).

The MSQ assesses career satisfaction along three dimensions, each corresponding to a separate scale. General Satisfaction is defined by a scale that is composed of all 20 items on the short form. Intrinsic Satisfaction is defined by responses to items 1, 2, 3, 4, 7, 8, 9, 10, 11, 15, 16, 17, 18, and 20, and Extrinsic Satisfaction by responses to items 5, 6, 12, 13, 14, and 19.

The General Satisfaction raw score was generated by summing the Likert scale responses for all twenty items on the MSQ. For classification purposes, the raw scores were then translated into percentile scores, using the norms for employed non-disabled workers provided in the MSQ manual. Percentile scores above 75 indicated high levels of career satisfaction, while scores below 24 represented low satisfaction. The scores for the Intrinsic and Extrinsic subscales were generated by summing the Likert scale responses from the relevant questions.

The MSQ has been used extensively since its development thirty years ago. Canonical correlation analysis of test-retest results for the long form of the MSQ produced maximum reliability coefficients of .89 over a one year period. The reliability coefficients for the short form were in a similarly high range. The median Hoyt reliability coefficients for the General Satisfaction scale ranged from .92 to .87; on the Intrinsic scale, the range was from .91 to .84; and for the Extrinsic satisfaction scale, the values ranged from .82 to .77.

The construct validity of the MSQ has been supported by factor analysis, which revealed two essential components, corresponding to internal and external sources of career satisfaction (Weiss et al., 1967). The concurrent validity of the MSQ can be inferred from analysis of variance data, which indicate that the MSQ can detect differences in career satisfaction between different occupational groups (Weiss et al., 1967).

Predictor Variables

Three sets of predictor variables corresponding to the above research hypotheses were used in this study: 1) the proportion of a participant's practice that was under managed care; 2) the practitioner's demographic characteristics; and 3) variables that represented practice financial characteristics, managed care business practices, managed care communications, and practitioners' experience of ethical dilemmas associated with managed care. The predictor variables were assessed by responses to items on the self-report questionnaire, the Practice of Psychology Survey (PPS).

The format and content of the researcher-developed PPS survey were derived from a number of sources, including Strom (1992a, 1994) and Sinnet & Holen (1993). The PPS contained 72 items, and was designed to assess pertinent practitioner demographic characteristics, as well as relevant aspects of both clinical practice and the role of managed care in the delivery of psychological services.

The survey contained three types of questions: items that required participants to provide a numerical response or percentage estimate (e.g., A-1 or A-8); items that involved selecting an answer from a limited range of responses (for example, A-2 or A-7); and items that required a response that was based on a 5-point Likert scale (e.g. B-29, C-37, or C-44). Completion time for the survey was estimated to be between 45 minutes and one hour.

The survey was divided into four sections: Demographic Information; Practice Information; Third Party Payors; and Managed Care. The survey also contained nine questions that were related to the measurement of the criterion variable of career satisfaction: items A-10, A-11, and items B-29 through B-35.

The first section, Demographic Information, was comprised of items A-1 through A-9, and required participants to answer questions related to their age, ethnicity, gender, years in practice, and income. The second section, Practice Information, was composed of items B-12 through B-28, and asked participants to provide responses to questions concerning the structure of their practice, the composition of their caseload, and the nature of their work environment (staff or group HMO, PPO, or private practice). The Third Party Payors section, which contained items C-36 through C-56, was concerned with the nature of the relationship that psychologists have with third parties, such as insurance companies or HMOs, that provide compensation for the provision of therapeutic services. The final section, Managed Care, was composed of items D-57 through D-71, and asked participants to describe their interactions with managed care companies and utilization review personnel.

The questions in the survey questionnaire cover six basic areas: practitioner demographics; practice structure; practice finances; managed care; managed care communications; and ethical dilemmas. Questions were included in the survey on the basis of two primary criteria. The first criterion was evidence from previous research

that suggested a connection between the content area and career satisfaction. For example, McKelvey and Webb (1995) found that among psychiatrists, career satisfaction was related to the subjects' age as well as the number of years that they had been in practice. The second criterion was the list of practitioner concerns contained in the APA's CAPP study (1996). The CAPP study list provided the rationale for including questions related to managed care, utilization review, practice income, ethical dilemmas, managed care referrals, and membership on managed care panels.

The practitioner demographic questions captured the information related to the service provider, including age, gender, type of degree, number of years in practice and theoretical orientation. The demographic information questions were represented by items A-1 through A-9 and B-26 through B-28.

The questions related to practice structure provided a picture of the practitioner's work setting, including caseload, client characteristics, and professional environment (group HMO, staff HMO, PPO, etc.). The practice structure questions were items B-12 through B-15 and B-17 through B-25.

The practice finance questions provided information on the number of managed care referrals, relative ease or difficulty in obtaining reimbursement, and increases or decreases in income related to managed care. The practice finances questions were represented by items B-16, C-36, C-37, D-69, and D-70.

The questions related to managed care addressed the practical aspects of service provision. They included items concerning the need for pre-authorization, the

number of sessions that are typically granted, and utilization review. The managed care questions were items C-38 through C-42, D-61 through D-66, D-68, and D-71.

The managed care communications questions were concerned with the interactions between the service provider and the managed care entity, both in writing and on the telephone. The communication items also addressed the relative ease or difficulty of establishing and maintaining contact with the managed care entity. The managed care communications questions were represented by items D-58, D-59, D-60, D-61, and D-67.

Finally, the ethical dilemma questions addressed insurance reporting, confidentiality, continuity of care, and the influence of reimbursement policies on diagnosis and treatment approach. The ethical dilemma questions were comprised of items C-43 through C-56.

Operationalizing Key Concepts

For the first research hypothesis, the predictor variable was the proportion of a provider's caseload that was reimbursed by third party payors, as measured by questions B-23, B-25, and D-70 of the PPS. The outcome variable was career satisfaction, as measured by the General Satisfaction, Intrinsic Satisfaction, and Extrinsic Satisfaction scale scores on the MSQ. For the second research hypothesis, the criterion variables were defined by the Intrinsic and Extrinsic Satisfaction scores on the MSQ. For the third research hypothesis, the independent variable was the provider demographic data derived from the PPS, and the outcome variable was career

satisfaction, as measured by the General Satisfaction scores on the MSQ. Finally, the predictor variables for the last research hypothesis were based on questions from the PPS that corresponded to practice finances, managed care business practices, managed care communications, and practitioners' experience of ethical dilemmas associated with third party payors and managed care. The outcome variables were the General Satisfaction, Intrinsic Satisfaction, and Extrinsic Satisfaction scores on the MSQ.

Procedure

The Research Office of the APA provided two identical sets of labels for the subject pool of 700 participants. The first set of labels was used for mailing the materials to the participants, and the second set of labels was used to address the follow-up postcard that was sent six weeks after the initial mailing. The Minnesota Satisfaction Questionnaire and the Practice of Psychology Survey were placed in an envelope, along with a cover letter, a consent form, a set of instructions, and a stamped pre-addressed return envelope.

The cover letter described the topic of the dissertation research, and invited the subjects to participate. The subjects in the study were completely anonymous. The survey forms were not coded in any way, nor was there be any personal identification information on the surveys (except for age and number of years of practice). No copies of the labels were made, and no records were made or kept of the identity of the participants.

The subjects were be asked to fill out the consent form and two questionnaires. Upon completion of the two instruments, the participants could return the materials in the pre-addressed and stamped return envelope. Six weeks after the initial mailing, a reminder postcard was sent to the entire subject pool. The card asked participants to complete the materials and return them in the pre-paid return envelope.

Data Analysis

The data analysis fell into two main areas. The first analysis addressed the MSQ, and employed descriptive statistics, including the mean, median, range, and standard deviation of the scores, to provide a picture of career satisfaction among psychologists who are active in providing psychological services. In addition, descriptive statistics were also used to identify interesting data from the Practice of Psychology Survey.

The second set of statistical analyses focused on the relationship between managed care and career satisfaction. For the first alternative hypothesis, a correlational analysis using Pearson's r statistic was used to assess whether involvement with managed care was related to career satisfaction. The second alternative hypothesis was examined using a paired sample t-test to investigate the relationship between intrinsic and extrinsic career satisfaction.

The final set of data analyses began with a principal components analysis on the items related to managed care and third party payors, to reduce the data and identify underlying factors. A regression analysis was performed on the factors to

inspect the relative contributions of each of the factors to the outcome variable of career satisfaction. Factors that were significantly related to the outcome variable were then examined using multiple regression to identify specific items that were associated with variation in career satisfaction.

CHAPTER 3

RESULTS

Description of the Sample

A total of 194 surveys were filled out and returned, which represented 28% of the subject pool. Thirty nine respondents did not meet the minimum criterion of 25 hours per week of direct service provision, and their protocols were removed from the data analysis, leaving a total of 155, or 22% of the subject pool.

Representative Characteristics of the Sample

The demographic characteristics of the practitioners in the study sample appeared to conform to the demographic data on the general membership of the APA (APA, 1995). The gender balance of this study - 56% male and 44% female - corresponded well with the APA statistics of 55% male and 45% female. The average age of the psychologists in the sample was 48.7 years old, compared with 49.5 for the APA as a whole. The psychologists in the survey had been in practice for an average of 13.5 years, which approximates the 16.8 years of the APA general membership.

The practice characteristics of the psychologists in the survey were also found to be similar to data generated by the CAPP study (APA, 1996). Approximately 41% of the survey sample was involved in private practice, which matched the 40.7% of the practitioners in the CAPP engaged in independent practice. Similarly, 11.6% of the study sample worked in medical settings, and a further 7.7 % were employed in government facilities, which corresponded with the 12% of the CAPP study

psychologists who worked in hospitals and the 7.1% who had positions in government facilities.

Demographic Information

The profile of the participants in the study reflected the demographic changes that have been taking place within the profession over the last ten years. While minorities were underrepresented in terms of the population as a whole - the sample was 92% Caucasian - it was more evenly balanced in terms of gender: 56% of the respondents were male, and 44% were female. The average participant was 49 years old, and had been in practice for 14 years.

Participants in the survey averaged 48 hours per week on the job, divided between 31 hours of billable time and 17 hours of time for which they received no reimbursement. Providing direct psychological services was the primary professional activity for most of the practitioners in the study: over 73% of their time was spent doing therapy. A substantial proportion of their time was devoted to non-reimbursable activities, with 10% consumed by utilization review, and 5% spent on billing. The balance of their professional time was spent on other activities, including teaching, supervision, and consultation.

Table 1: Work Time and Activities

Variable	Mean	Std. dev.	Range	Minimum	Maximum
Number of Billable Hours	31.3	11.6	94	6	100
Number of Non-billable Hours	16.8	11.7	60	0	60
Percentage Worktime: Therapy	73.5	18.1	100	0	100
Percentage Worktime: Billing	5.3	6.7	35	0	35
Percentage Worktime: UR	10.0	9.5	50	0	50
Percentage Worktime: Other	11.7	16.0	100	0	100

The psychologists in the study were very active, with an average caseload of 39 clients per week, or approximately 8 patients per day. The majority of caseloads were made up almost exclusively of adults, with women clients outnumbering men by a ratio of 3 to 2. White-collar professionals represented 40% of all caseloads, followed by blue-collar workers (27%), students (18%), and the unemployed (15%). Though Caucasians represented 78% of all clients seen, psychologists in the study also provided psychological services to minority clients, who constituted 22% of the average caseload. Relatively small proportions of the practitioners in the study specialized in the treatment of children and adolescents - 11% and 7% respectively.

Table 2: Average Caseload

Variable	Mean	Std. dev.	Range	Minimum	Maximum
Number of cases	39.1	20.1	94	6	100
% Caseload: Males	43.6	19.7	100	0	100
% Caseload: Minority	21.4	22.2	100	0	100
% Caseload: Caucasian	78.4	22.2	100	0	100
% Caseload: White Collar	39.8	29.4	100	0	100
% Caseload: Blue Collar	26.9	21.9	95	0	95
% Caseload: Students	18.6	23.9	100	0	100
% Caseload: Unemployed	15.1	25.0	100	0	100

Table 3: Type of Clients in Caseload

Variable	Adults	Adolescents	Children
Clients in Caseload Primarily:	80.5	7.8	11.7

The majority of psychologists in the survey - over 85% - practiced in urban or suburban communities. Most of the psychologists were independent practitioners, with 41 % in solo practice and 29% involved in a group independent practice. A substantial proportion of the psychologists in the study worked in medical facilities (11%), followed by those employed in government institutions (8%) and community mental

health centers (8%). A small segment of the practitioners worked in staff or group HMO settings - less than 2%.

Table 4: Practice Location

Variable	Urban	Suburban	Rural
Percentage of Practitioners	49%	37.9%	13.1%

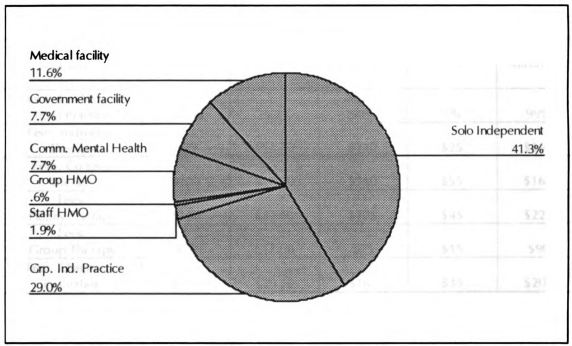

Figure 1: Practitioner Work Settings

The average caseload was divided evenly between private fee-for-service and contractual fee-for-service clients (i.e. Medicare or preferred provider referral), with

each group representing about 44% of all patients. The balance of the caseload was comprised of clients seen under capitated contractual agreements. The mean fee for an hour of individual, couples, or family therapy was $99. Group therapy patients were charged an average of $50, roughly half of the fee for individual patients, and assessment sessions averaged approximately $110. More than half of the average caseload were charged a reduced rate for services, and 4% of all patients were treated on a *pro bono* basis.

Table 5: Fee Structure

Variable	Mean	Std. dev.	Range	Minimum	Maximum
Percent of Income from Practice	71.5%	23.7%	99%	1%	99%
Fees: Individual Therapy	$99	$21.30	$140	$25	$165
Fees: Couples Therapy	$100	$20.20	$110	$55	$165
Fees: Family Therapy	$100	$23.60	$175	$45	$220
Fees: Group Therapy	$50	$17.00	$75	$15	$90
Fees: Diagnostic Evaluation	$112	$29.80	$165	$35	$200

The median annual income for the psychologists in the survey was between $80,000 to $100,000. Although the majority of the practitioners in the study indicated that their household had two sources of income, the revenue generated by their practices represented 70% of their family's total income.

Table 6: Total Family Income

$25,000 - 39,000	$40,000 - 59,000	$60,000 - 79,000	$80,000 - 99,000	$100,000 - 119,000	$120,000 - 139,000	Over $140,000
3.9%	11.2%	17.1%	19.1%	19.7%	11.8%	17.1%

Third Party Payors and Managed Care

Third party payors play an active role in the provision of psychotherapy. The degree of third party or managed care involved can be assessed along two dimensions: 1) the percent of caseloads that receive services under contractual agreements with third parties, and 2) the percentage of practitioners in the survey who treat clients under those agreements.

There were also four direct measures of the degree of managed care involvement with the practitioners' caseloads: 1) the percentage of the practitioner's caseload that required prior approval of treatment plans; 2) the percentage of clients who were treated under a contractual agreement for a reduced fee (e.g. HMOs and PPOs); 3) the percentage of the caseload that was seen on a capitated basis; and 4) the proportion of patients that used third party funds to pay for their treatment under a contractual fee-for-service plan. The data were consistent: 43% of the practitioners in the survey required prior approval of treatment plans; 43% of the clients were treated under a contractual agreement for a reduced fee; 10% of the clients were seen as a result of capitated contracts; and 53% of the total client caseload received funds for their treatment from third party payors.

Table 7: Third Party Payors and Treatment

Variable	Mean	Std. dev.	Range	Minimum	Maximum
% Cases: Pay Full Rate	42.0	32.6	100	0	100
% Cases: Pay Reduced Rate	52.3	32.0	100	0	100
% Cases: Free (pro bono)	4.0	5.5	25	0	25
% Cases: Fee-for-Service	43.7	33.8	100	0	100
% Cases: Contract Fee-for-Service	43.1	33.2	100	0	100
% Cases: Capitated Contract	10.3	23.8	100	0	100
% Cases: Prior Approval	43.2	34.6	100	0	100
% Cases: Third Party Determined Tx	15.4	26.5	100	0	100

These same four items also served as indirect measures of the percentage of practitioners who were involved with third party payors or managed care. Approximately 70% of the psychologists in the study required prior approval of treatment plans before receiving authorization for treatment. Similarly, 78% of the practitioners delivered services under preferred provider agreements, and 90% treated patients for reduced fees under contractual fee-for-service plans. Delivering services under capitated contracts appeared to be the least popular alternative, and involved only 10% of the psychologists in the survey.

The impact of third party payors on caseloads was less clear - 25% of the practitioners reported a moderate or substantial increase in the demand for their

services, while 36% of the respondents stated that third party payors had a negative impact on their referrals. Approximately 40% of the psychologists in the survey indicated that they relied on third party payors for patient referrals.

Table 8: Third Party Impact on Demand for Services

Variable	Greatly Increased Caseload	Moderately Increased Caseload	No Impact	Moderately Decreased Caseload	Greatly Decreased Caseload
Third Party Impact on Demand for Services	7.1 %	18.4 %	38.1 %	32.0 %	4.1 %

Table 9: Practitioner Reliance on Third Party Referrals

Variable	Not at all	Very little	Moderately	Greatly
Depend on Third Party Referrals	26.2 %	29.0 %	24.8 %	17.9 %

Interactions with Third Party Payors and Managed Care

Communications

The practitioners in the study reported a wide variety of response times in their attempts to contact managed care personnel. Less than 15% percent of the respondents indicated that case managers were readily available by phone. The balance of the sample was divided between those who reported having to wait less than ten minutes (25%), and those for whom waits of ten minutes or longer were

typical (60%). There was a similar disparity in terms of the time required for managers to return messages: one third of the sample indicated that their messages were returned promptly or within 24 hours, while half of the practitioners reported having to wait 48 hours or longer.

Table 10: Case Manager Availability

Variable	Readily Available	Occasional Waits over 10 Minutes	Frequent Waits over 10 Minutes	Usually Longer than 10 Minutes	Long Waits Typical
Availability of Case Managers	13.2 %	25.6 %	15.5 %	17.1 %	28.7 %

Table 11: Time Required for Messages to be Returned

Variable	Promptly	Frequently within 24 Hours	Usually within 24 Hours	Usually within 48 Hours	Usually over 48 Hours
Time Required for Messages to be Returned	4.6 %	28.5 %	18.5 %	29.2 %	19.2 %

Most of the survey psychologists received authorization to provide services within one week of their request. However, a considerable portion of the psychologists (48%) indicated that they had to wait two weeks or longer. Third party payors and managed care companies also varied in terms of the amount of time required to authorize medical consultations and emergency services. The majority of case managers responded within 24 hours, but 30% of the practitioners indicated that authorization for emergency services regularly required more than 48 hours.

Table 12: Time Required for Authorization of Treatment

Variable	Within 1 Week	Usually Within 1 Week	Usually Within 2 Weeks	Occasionally Longer Than 2 Weeks	Usually Longer than 2 Weeks
Wait Time for Authorization	**30.7 %**	**21.3 %**	**17. 3 %**	**14.2 %**	**16.5 %**

Table 13: Time Required for Emergency Authorization

Variable	Promptly	Usually within 24 Hours	Occasionally Longer than 24 Hours	Usually Within 48 Hours	Usually Over 48 Hours
Wait Time for Emergency Authorization	15.8 %	30.8 %	24.2 %	15.8 %	13.3 %

Personnel

The psychologists in the study varied in their assessment of the professionalism of managed care personnel. Most of the respondents rated the professionalism among case managers as adequate or better, but 25% of the sample reported that managers were unskilled or occasionally unprofessional. Though most of the practitioners had a positive view of the professionalism among managed care employees, they had a strong reaction to the fact that many utilization review personnel are not psychologists. Only 3% of the sample indicated that the issue was not relevant, while over 57% said that they were considerably or profoundly distressed.

Table 14: Professionalism of Managed Care Personnel

Variable	Highly Professional	Professional	Adequate	Occasionally Unprofessional	Unprofessional
Professionalism of MC Personnel	5.4 %	24.0 %	45.0 %	19.4 %	6.2 %

Table 15: Licensure Status of UR Personnel

Variable	No Concern	Small Concern	Moderate Concern	Considerable Distress	Profound Distress
Licensure Status of UR Personnel	3.0 %	6.7 %	32.6 %	32.6 %	25.2 %

Respondents also varied in their ratings of the extent to which case managers collaborated in the course of a case: 40% of the practitioners indicated that their relationship was usually collegial and constructive, but 20% of the sample stated that those interactions were adversarial and counter-productive. While the vast majority of the practitioners stated that dialogue with case managers was reasonable and appropriate, a significant proportion of the psychologists - 20% - had a negative experience with reauthorization. These practitioners stated that they had difficulty in obtaining additional sessions, and that case managers were often contentious and rigid. This situation may have been exacerbated by the absence of clearly stated criteria for reauthorization - only 22% of the sample indicated that utilization review personnel used clear and concise written rules to assist in the decision making process.

Table 16: Case Manager Collaboration with Practitioners

Variable	Constructive	Usually Constructive	Occasionally Constructive	Occasionally Adversarial	Adversarial
MC Collaboration with Practitioners	10.2 %	30.5 %	36.7%	16.4%	6.3 %

Table 17: Experience with Reauthorization

Variable	Dialogue Reasonable	Justification Required	Sessions Granted/Denied Without Justification	Difficulty Obtaining Sessions	Managers Contentious and Rigid
Practitioners' experience with reauthorization	17.6 %	53.6 %	12.0 %	13.6 %	3.2 %

Table 18: Utilization Review Criteria

Variable	Written: Clear and Concise	Unwritten: Clear and Consistent	Unwritten: Unclear and Inconsistent	No Stated Criteria
UR Criteria	22.0 %	17.2 %	29.3 %	31.7 %

Influence over Clinical Decisions

Most psychologists in the survey felt that case managers played a central role in clinical decisions regarding patient treatment: approximately 44% of all patients required prior approval of treatment plans by a third party before treatment is authorized. Only 14% of the practitioners stated that they retained a strong degree of

control over their treatment decisions. The balance of the respondents - 86% - indicated that case managers exerted various degress of control over the clinical decision-making process: 33% of the psychologists in the study reported that they retained moderate control over treatment decisions; 35% stated that they had some control; 12 % indicated that they had very little control, and 6% stated that they had no control at all.

Table 19: Perceived Practitioner Control Over Treatment Decisions

Variable	Strong Control	Moderate Control	Some Control	Hardly Any Control	No Control
Perceived Practitioner Control Over Tx Decisions	14.6 %	32.3 %	34.6 %	12.3 %	6.2 %

Third party payors were reported to influence treatment in a variety of ways. A considerable portion of the psychologists in the survey (44%) felt that third party guidelines for reimbursement were a moderate or strong consideration in formulating a diagnosis. Third parties were also reported to exert an influence over treatment decisions: 43% of the practitioners in the study indicated that they felt pressure to adjust their treatment decisions in order to stay on provider panels. Once treatment is approved, third party payors also set strong limits on its duration: psychologists in the survey requested an average of eleven therapy sessions for their patients, but received only seven.

Table 20: Managed Care Influence over Treatment

Variable	No Impact	Very Little	Moderate	Great
Third Party Influence on Diagnosis	28.6 %	27.9 %	30.0 %	13.6 %
Third Party Influence over Tx Decisions	28.1 %	28.9 %	27.4 %	15.6 %

Table 21: Average Sessions Requested and Authorized

Variable	Mean	Std. Dev.	Range	Minimum	Maximum
Average Sessions Requested	10.5	5.8	46	4	50
Average Sessions Authorized	7.0	3.6	24	1	25

The degree of managed care control over treatment decisions was significantly related to the survey psychologists' assessment of impact that third parties had on the development of treatment relationships ($p < .0001$), and was also linked to the practitioners' views of the effect that third parties had on the overall quality of treatment. Only 8% of the participants in the survey felt that third parties had a positive impact on the development of treatment relationships, and less than 6% believed that third party payors had a positive influence on the quality of treatment. Most of the respondents felt that third party payors and managed care had an overall negative impact: 58% indicated that third parties had a moderately or highly negative

influence on treatment relationships, and 53% stated that third parties have a moderately or highly negative impact on treatment quality.

Table 22: Third Party Impact on Treatment Relationships and Quality

Variable	Highly Positive	Moderately Positive	None at all	Moderately Negative	Highly Negative
Third Party Impact on Tx Relationships	.7 %	7.5 %	33.3 %	48.3 %	10.2 %
Third party Impact on Tx Quality	.7 %	4.8 %	40.1 %	46.3 %	8.2 %

Ethics

Working with third party payors led to ethical conflicts for many of the psychologists in the study: 39% of the respondents indicated that acceptance of third party funds created treatment dilemmas. A substantial portion of the practitioners have submitted deliberately inaccurate diagnoses in order to conform with reimbursement guidelines: 35% of the respondents had given a less severe diagnosis than was warranted, and 60% of the psychologists in the sample had given patients a more severe diagnosis than was appropriate. Third party payors also played a central role in determining how treatment is conducted: 58% of the respondents reported that third parties had influenced their treatment approach (e.g., using behavioral versus insight therapy), and 40% stated that they had selected the treatment modality (e.g., group versus individual therapy) on the basis of reimbursement guidelines. Furthermore, 70% of the practitioners indicated that they had reported conjoint or family therapy as

individual treatment in order to comply with reimbursement guidelines. Finally, 79% of the psychologists in the survey indicated that patients had received less treatment than was needed due to limitations in treatment benefits.

Table 23: Incidence Rate of Ethical Dilemmas

Variable	Never	Rarely	Occasionally	Frequently
Given Less Severe Diagnosis	64.5%	20.3%	9.4%	5.8%
Given More Severe Diagnosis	40.0%	26.5%	25.8%	7.6%
Reported Family/Couples as Individual Tx	28.8%	24.2%	35.6%	11.4%
Third Party Influenced Tx Modality	60.0%	20.8%	14.4%	4.8%
Third Party Influenced Tx Approach	42.7%	14.5%	25.0%	17.7%
Given Less Tx than was Necessary	20.8%	20.8%	31.5%	26.9%

Table 24: Acceptance of Third Party Funds and Treatment Dilemmas

Variable	No Impact	Very Little	Moderate	Great
Third Parties Create Tx Dilemmas	28.8%	28.9%	21.6%	17.3 %

The emotional responses to these ethical dilemmas varied in their intensity. More practitioners were comfortable with giving patients less severe diagnoses (37%) than with any of the other ethical incidents outlined in the survey. Conversely, only 9% of the psychologists were comfortable with selecting a treatment approach to conform

with third party reimbursement guidelines. More practitioners were distressed by the prospect of patients receiving insufficient treatment than by any other dilemma (58%). Once again, giving patients a less severe diagnosis appeared to be the least disturbing situation, with only 12% of the sample indicating moderate or severe distress.

The emotional responses to ethical dilemmas also varied in the strength of their relationship to the precipitating incidents: an increase in the incidence rate of ethical dilemmas was not necessarily associated with a rise in the intensity of a respondent's emotional reaction. Overall, the strongest relationship between the occurrence of ethical conflicts and practitioners' emotional reactions involved patients receiving insufficient treatment ($p < .0001$).

Table 25: Reactions to the Occurrence of Ethical Dilemmas

Variable	Comfortable	Slight discomfort	Moderate discomfort	Moderately Disturbed	Greatly Disturbed
Given Less Severe Diagnosis	41.7%	22.9%	22.9%	10.4%	2.1%
Given More Severe Diagnosis	17.5%	40.0%	28.8%	8.8%	5.0%
Reported Family Tx as Individual Tx	28.7%	38.3%	20.2%	10.6%	2.1%
Third Party Influenced Tx Modality	22.0%	38.0%	14.0%	16.0%	10.0%
Third Party Influenced Tx Approach	11.1%	25.0%	27.8%	18.1%	18.1%
Given Less Tx than was Necessary	1.0%	16.8%	22.8%	30.7%	28.7%

Working within a managed care framework or with third party payors can create divided loyalties. While 70% of the practitioners held that the therapist is the

agent of the client, 16% of those surveyed felt that they represent both the patient and the party that pays for the treatment, and 12% subscribed to the view that they are the agent of the patient, the party that purchased the coverage, and the party that pays for the treatment.

Table 26: Role of the Therapist

Variable	The Patient	Purchaser	Payor	Patient and Payor	Patient, Payor, and Purchaser
Therapist Role	69.7 %	2.1 %	1.4 %	15.5 %	11.3 %

Finally, many psychologists are concerned about case management processes used by insurance companies. None of the psychologists in the study endorsed the idea that utilization review enhanced confidentiality, and 37% of the practitioners in the sample indicated that those procedures represent a serious threat to the security of patient records.

Table 27: Peer Review and Confidentiality

Variable	Enhances Confidentiality	No Effect	Potential for Breaches	Occasionally Jeopardizes Confidentiality	Greatly Jeopardizes Confidentiality
Peer Review and Confidentiality	0%	3.6 %	38.6 %	21.4 %	36.4 %

Overall Impact of Managed Care

There was a strong agreement among the psychologists in the study about the overall impact of managed care on the practice of psychology. None of the practitioners in the survey felt that managed care resulted in a marked improvement of services, and only 4% indicated that it had a moderately beneficial impact. Most of the psychologists (91%) believed that managed care was a negative influence: 39% felt that managed care had a moderately negative impact, and 52% stated that it had a marked adverse influence on services. These percentages correspond with the outcome data from the CAPP study (APA, 1996), which found that 89% of the solo and group independent practitioners believed that managed care had an overall negative impact on the practice of psychology.

Table 28: Overall Impact of Managed Care

Variable	Marked Improvement	Moderate Improvement	No Influence on Services	Moderate Adverse Impact	Marked Adverse Impact
Impact of Managed Care	0 %	4.9 %	4.2 %	39.2 %	51.7 %

Satisfaction with Managed Care

The study assessed satisfaction with managed care through a number of specific items in the Study on the Practice of Psychology questionnaire. The items (B-29 through B-35) addressed relationships with managed care personnel, as well as the

impact that third parties had on the provision of psychological services. The participants were asked to respond to the questions on a 5-point Likert scale, with 1 representing "very dissatisfied", and 5 indicating "very satisfied". The scores on this constellation of questions could range from a minimum of 7 to a maximum of 35.

The mean total score for these seven items was 18.5, with a low score of 7, and a high of 31, and a standard deviation of 6. The average item response was 2.65, with a standard deviation of .84, with a high of 4.42 and a low of 1. Using the Likert scale keys, this mean score suggests that the psychologists in the survey were dissatisfied with managed care and utilization review.

Table 29: Overall Satisfaction with Managed Care

Variable	Mean	Std. Dev.	Range	Minimum	Maximum
Satisfaction with Managed Care	18.5	6.0	24	7	31

Investigating the individual item averages provided a more accurate representation of the participants' satisfaction with managed care. The highest relative degree of satisfaction, as measured by the SPP, concerned the practitioners' ability to use their own treatment approaches. The average response for this item was 3.25, which corresponds to "neither satisfied nor dissatisfied", and it was the only item to earn this designation by averaging over 3 on the Likert scale. The practitioners in the study were least satisfied with the acknowledgment that they received from case

managers for doing a job well: the average score was 2.12, which falls into the category of "dissatisfied". The balance of the items - the competence, professionalism, and management skills of utilization review personnel, the ability to use their own clinical judgment, and their working relationships with case managers - were all in the "dissatisfied" range.

Table 30: Satisfaction with Managed Care

Variable	Very Satisfied	Satisfied	Neither	Dissatisfied	Very Dissatisfied
MC Personnel Competence	0%	13.6%	26.5%	32.6%	27.3%
MC Personnel Professionalism	0%	24.2%	26.5%	25.8%	23.5%
MC Management Skills	0%	15.6%	25.0%	35.9%	23.4%
MC Working Relationship	3.1%	31.8%	33.3%	23.3%	8.5%
Use own Clinical Judgment	5.3%	37.6%	10.5%	27.8%	18.8%
Use own Treatment Approaches	9.9%	48.9%	9.2%	20.6%	11.5%
Acknowledgment for job well done	1.0%	11.6%	26.8%	19.6%	41.1%

Career Satisfaction

This study used a number of career satisfaction measures, both global and specific. The first global index of career satisfaction was the number of practitioners who would choose psychology as a career if they were given a second opportunity. While 70% of the psychologists in the study reported that they would choose psychology again, 30% indicated that they would pursue a different career. The second global measure of

career satisfaction addressed the percentage of psychologists who were planning on changing careers within the next five years. A substantial proportion of the psychologists in the survey - 13% - stated that they intended to make a career shift in the near future.

The Minnesota Satisfaction Questionnaire (MSQ) served as the criterion measure for this study. Overall, the distribution of scores had a negative skew. Factor analysis confirmed the two factor structure corresponding to Intrinsic and Extrinsic Satisfaction, as outlined by Weiss, Dawis, England, and Lofquist (1967).

Scores on the General Satisfaction scale of the MSQ can range from a minimum of 20 to a maximum of 100. Weiss and his colleagues (1967) recommend transforming the raw scores into percentile scores before interpreting individual MSQ protocols. Scores above the 75th percentile are defined as high satisfaction, while scores below the 25th percentile are regarded as indicators of low levels of career satisfaction. In the manual for the MSQ, the authors provided a set of norms for employed workers for comparative purposes.

The mean total score on the MSQ in this study was 75.9, with a standard deviation of 11.27, a low score of 31 and a high score of 93. According to the norms, a raw score of 75 would correspond to the 45th percentile: consequently, the mean General Satisfaction score for psychologists in the survey would fall slightly below the middle of the average range of satisfactio

The MSQ also renders scores on two subscales: Intrinsic Satisfaction and Extrinsic Satisfaction. The potential scores on the Intrinsic Satisfaction lie between a minimum of 14 and the maximum of 70. The mean Intrinsic Satisfaction scale score was 57.7, with a standard deviation of 7.64, and a range from 20 to 70. Finally, scores on the Extrinsic Satisfaction scale can range from a minimum of 6 to a maximum of 30. The mean Extrinsic Satisfaction scale score was 19.3, with a standard deviation of 4.56, a low score of 6, and a high score of 30.

Table 31: Minnesota Satisfaction Questionnaire Scores

Variable	Mean	Std. Dev.	Range	Minimum	Maximum
General Satisfaction	75.9	11.2	62	31	93
Intrinsic Satisfaction	57.7	7.64	50	20	70
Extrinsic Satisfaction	19.3	4.56	24	6	30

Hypothesis Testing

Research Hypothesis #1

The first research hypothesis proposed that psychologists' career satisfaction would vary as a function of the percentage of the practitioners' caseload that was under managed care. The study used four separate measures of the percentage of managed care involvement: 1) the proportion of cases requiring prior approval of treatment plans by a third party; 2) the percentage of cases that were contractual fee-for-service (e.g. Medicare or preferred provider agreements); 3) the proportion of cases that received services under capitated contracts; and 4) the percentage of practitioners' income that was derived from third party payments. Multiple regression was used to examine the relationship among the variables.

The results supported the research hypothesis: General Satisfaction was significantly related to both the percentage of income that was derived from third party payments ($p<.01$) and the percentage of cases that were contractual fee-for-service ($p<.05$). The percentage of income derived from third party payments was negatively correlated with General Satisfaction: increased income from third party sources was associated with lower General Satisfaction scores. Overall, these two variables accounted for 9% of the variance in General Satisfaction.

Intrinsic Satisfaction was also significantly related to both the percentage of income derived from third party payments ($p<.001$) and the percentage of cases that were contractual fee-for-service ($p<.05$). Third party income was had an inverse

relationship with Intrinsic Satisfaction: higher percentages of income derived from third party sources was associated with lower Intrinsic Satisfaction. Overall, third party income and contractual fee-for service caseload explained 8% of the variation in Intrinsic Satisfaction scores. Extrinsic Satisfaction was not related to any of the four measures of managed care involvement.

Table 32: Managed Care Involvement and Career Satisfaction

Variable	General Satisfaction	Intrinsic Satisfaction
Percentage of Income from Third Party Payments	$p < .01$ $r = -.18$	$p < .001$ $r = -.20$
Percentage of Cases: Contractual Fee-for-Service	$p < .05$ $r = .02$	$p < .05$ $r = .01$

Research Hypothesis #2

The second research hypothesis proposed that the Intrinsic Satisfaction scores on the MSQ would be greater than the Extrinsic Satisfaction scores. A simple comparison between the total scores on the two scales would be misleading, due to the disparity in the number of items on each scale: the Intrinsic Satisfaction scale contains 14 items, whereas the Extrinsic Satisfaction scale has only 6. To facilitate an accurate comparison between the two measures of satisfaction, the item responses were summed, and then divided by the total number of items, rendering an average Intrinsic Satisfaction item score and an average Extrinsic Satisfaction item score. These scores were then compared using a paired sample t-test. The results supported the research hypothesis: the Intrinsic Satisfaction scores were significantly higher than the Extrinsic Satisfaction scores ($p<.001$).

Table 33: t-test for Paired Samples

Variable	Mean	SD	SE of Mean
Average Intrinsic MSQ	4.16	1.08	.092
Average Extrinsic MSQ	3.28	.77	.066

Paired Differences					
Mean	SD	SE of Mean	t-value	df	2-tail Sig
.877	1.102	.093	9.39	138	$p< .001$

95% CI (.693, 1.062)

Research Hypothesis #3

The third research hypothesis suggested that career satisfaction would vary as a function of practitioner demographic characteristics. The relationship among the variables was assessed using the Pearson r correlation for the continuous variables, and analysis of variance (ANOVA) for the categorical variables. Alpha level was set at .01 to reduce the chance of Type 1 error.

General Satisfaction was significantly related to six variables. Overall, male psychologists were significantly more satisfied with their career than females ($p<.01$). Both family income and the percentage of clients who were white collar professionals were positively correlated with General Satisfaction ($p< .01$): higher income and increased proportion of white collar clients were both associated with higher levels of satisfaction. Conversely, work time spent doing non-reimbursable tasks and work time involved with utilization review were negatively correlated with General Satisfaction ($p<.01$): increased time spent in non-billable tasks and utilization review were both associated with lower career satisfaction. Work setting was also significantly related to General Satisfaction ($p<.01$). Practitioners involved in solo independent or group independent practice had the highest levels of General Satisfaction, while psychologists employed in community mental health facilities and staff HMOs had the lowest.

After the initial statistical analysis, the six variables - gender; family income; percentage of clients that were white collar workers; worktime spent in non-billable

tasks; worktime involved in utilization review; and work setting - were entered in a multiple regression equation to determine the amount of variance in General Satisfaction that was accounted for by the demographic variables. Altogether, these six variables accounted for 36% of the variance in General Satisfaction.

Table 34: Demographic Variables Related to General Satisfaction

Demographic Variable	Probability Correlation Coefficient
Gender	$p < .01$ $r = -.260$
Family Income	$p < .01$ $r = .262$
Percentage of Caseload: White Collar Clients	$p < .01$ $r = -.298$
Worktime Spent on Non-billable Tasks	$p < .01$ $r = -.241$
Worktime Involved with Utilization Review	$p < .01$ $r = -.262$
Work Setting	$p < .01$ $r = .265$

Research Hypothesis #4

The fourth research hypothesis proposed that career satisfaction would vary as a function of predictors representing managed care business practices, managed care communications, and practitioners' experience of ethical dilemmas associated with third party payors and managed care. The Practice of Psychology Survey data related to these predictor variables was reduced through principle components factor analysis, using a Varimax rotation. Following the data reduction, the relationships among the variables were examined using multiple regression.

The initial factor analysis revealed multiple collinearity among the variables. A preliminary analysis suggested that the fourteen ethics questions might have been responsible for the collinearity. The rationale for this perception was based on the nature of the questions: answering the emotional response items (C-44, C-46, C-48, C-50, C-52, and C-54) was predicated on the occurrence of the precipitating ethical dilemma (survey items C-43, C-45, C-47, C-48, C-51, and C-53).

The fourteen ethics questions were removed, and the analysis was rerun successfully, resulting in a final three factor structure. The three factors had Eigenvalues of 6.7, 2.7, and 1.6 respectively. Variables with a factor loading of less than .40 were eliminated. Examination of the data revealed three discrete factors, with no variables having multiple factor loadings, and with all variables except demand for services included in one of the three factors. Analysis of the component variables allowed the three factors to be defined as follows: 1) Managed Care Interactions, composed of

fourteen items; 2) Managed Care Influence over Treatment, comprised of five items; and 3) Allotment of Treatment Sessions, containing two items. A multiple regression analysis revealed that both General Satisfaction ($p<.05$) and Extrinsic Satisfaction ($p<.001$) were significantly related to Managed Care Interactions. The data also showed that Intrinsic Satisfaction was significantly correlated with factor 2, Managed Care Influence over Treatment ($p<.01$).

Having ascertained that the first factor representing managed care or third party variables was significantly related to both General Satisfaction and Extrinsic Satisfaction, and that the second factor was significantly associated with Intrinsic Satisfaction, the data analysis followed with an examination of the relationship between the individual component variables of the two factors and the three outcome measures. The purpose of this additional investigation was to identify the specific variables that were associated with the three outcome measures - General Satisfaction, Intrinsic Satisfaction, and Extrinsic Satisfaction. Identification of the individual variables that contribute to career satisfaction may be useful in providing a point of departure in future efforts to improve the current relationship between mental health practitioners and third party payors.

Because of the large number of items contained in the first factor, Managed Care Interactions, the component variables were divided into three subfactors for purposes of data analysis. The purpose of this subdivision was to provide a more accurate assessment of the relationship between the component variables and the

outcome measure: a regression analysis containing fourteen items may omit some significant contributions. The first subfactor was defined as the Impact of Third Parties, which included four items: 1) the overall impact of managed care on the practice of psychology; 2) the effect of third party payors on the quality of care; 3) the impact of third party payors on the development of treatment relationships; and 4) third party payors' influence over clinical decisions. The second subfactor was termed Timeliness, and contained items related to the availability of case managers, the time required for messages to be returned or treatment to be authorized, and the amount of time required for services to be reimbursed. The third subfactor was termed Personnel, and was comprised of items concerning collaboration with case managers, practitioners' experiences with reauthorization, and the licensure status and professionalism of managed care personnel.

Multiple regression analysis showed that General Satisfaction was significantly related to four specific variables: the availability of case managers ($p<.01$); the impact of third party payors on treatment relationships ($p<.01$); the licensure status of managed care personnel ($p<.01$), and the influence of third party payors over treatment decisions ($p<.05$). These four variables accounted for 15 % of the variance in General Satisfaction.

Intrinsic Satisfaction was also significantly correlated with four variables: the influence of third party payors over treatment decisions ($p<.01$); the impact of third parties on treatment relationships ($p<.01$); the availability of case managers ($p<.01$);

and the professionalism of managed care personnel ($p<.05$). Overall, these four items accounted for 12% of the variance in the Intrinsic Satisfaction scores.

Finally, Extrinsic Satisfaction was significantly related to four variables: the overall impact of managed care on the practice of psychology ($p<.01$); the availability of case managers ($p<.001$); the licensure status of utilization review personnel ($p<.001$), and the impact of third party payors on the demand for practitioner services ($p<.05$). These four variables were responsible for 16% of the variance in Extrinsic Satisfaction.

A separate factor analysis was performed on the fourteen ethics questions, which revealed a three factor structure with multiple collinearity. The first twelve questions were then divided into odd and even numbered items, which corresponded to the occurrence of ethical dilemmas and practitioners' emotional reactions to those situations. Separate factor analyses were completed on the two groups of items, without any further indications of multicollinearity. The occurrence questions were grouped into a one factor solution, while the reaction items resolved into two factors. The Pearson correlation coefficient was used to examine the relationship between the occurrence factor and the outcome measures, and multiple regression was used to examine the relationship between the occurrence and emotional reaction factors and the criterion variables. Review of the data indicated that none of the three outcome measures were related to the occurrence of ethical dilemmas, but that all three were significantly correlated with practitioners' reactions to those ethical conflicts.

Multiple regression analysis revealed that General Satisfaction, Intrinsic Satisfaction, and Extrinsic Satisfaction were all related to practitioners' reactions to two specific situations: 1) reporting family or couples treatment as individual therapy ($p<.01$); and 2) selecting a treatment approach to conform with third party reimbursement guidelines ($p<.01$). Overall, practitioners who had stronger negative reactions to these two ethical dilemmas reported lower levels of career satisfaction across all three domains: General Satisfaction, Intrinsic Satisfaction, and Extrinsic Satisfaction. In addition, Extrinsic Satisfaction was also significantly related to practitioners' views on the impact of utilization review on confidentiality ($p<.05$): psychologists who thought that peer review processes used by insurance companies had a negative impact on patient confidentiality reported lower levels of Extrinsic Satisfaction.

Table 35:
Third Party Payor and Managed Care Variables Related to Career Satisfaction

General Satisfaction	Intrinsic Satisfaction	Extrinsic Satisfaction
Ethics: Reporting Family/Couples Treatment as Individual Therapy $p < .01$ $r = -.432$	Ethics: Reporting Family/Couples Treatment as Individual Therapy $p < .01$ $r = -.444$	Availability of Case Managers $p < .001$ $r = -.272$
Availability of Case Managers $p < .01$ $r = -.261$	Third Party Payors' Influence over Treatment Decisions $p < .01$ $r = -.282$	Licensure Status of UR Personnel $p < .001$ $r = -.306$
Third Parties' Impact on the Treatment Relationship $p < .01$ $r = -.280$	Ethics: Selecting a Treatment Approach to Conform with Reimbursement Guidelines $p < .01$ $r = -.323$	Overall Impact of Managed Care on the Practice of Ψ $p < .01$ $r = -.240$
Ethics: Selecting a Treatment Approach to Conform with Reimbursement Guidelines $p < .01$ $r = -.416$	Third Parties' Impact on the Treatment Relationship $p< .01$ $r = -.242$	Ethics: Reporting Family/Couples Treatment as Individual Therapy $p < .01$ $r = -.290$
Licensure Status of UR Personnel $p < .01$ $r = -.213$	Availability of Case Managers $p < .01$ $r = -.188$	Ethics: Selecting a Treatment Approach to Conform with Reimbursement Guidelines $p < .01$ $r = -.389$
Third Party Payors' Influence over Treatment Decisions $p < .05$ $r = -.226$	Professionalism of Managed Care Personnel $p < .05$ $r = -.175$	Ethics: Peer Review Potential for Jeopardizing Confidentiality $p < .05$ $r = -.239$
		Impact of Third Party Payors on Demand for Services $p < .05$ $r = -.211$

Adding ethics items to the multiple regression equations resulted in considerable gains in the amount of explained variance in the criterion measures. Including the two ethics items into the regression equation for General Satisfaction increased the explained variance from 15% to 41%. Adding the same two variables to the Intrinsic Satisfaction regression equation raised the explained variance from 12% to 32%. Finally, including the three additional ethics items to the regression equation for Extrinsic Satisfaction increased the explained variance from 16% to 36%.

Finally, a hierarchical regression was performed to examine the amount that statistically significant managed care and third party variables contributed to the variance in all three types of satisfaction scores, while controlling for the influence of the demographic variables. A review of the data analysis showed that six managed care and third party payor predictor variables were significantly related to General Satisfaction: the availability of case managers; the impact of third party payors on treatment relationships; the licensure status of managed care personnel; the influence of third party payors over treatment decisions; reporting family or couples treatment as individual therapy; and selecting a treatment approach to conform with third party reimbursement guidelines. Altogether, these six variables accounted for 25.5% of the variation in General Satisfaction scores, after controlling for the influence of the significant demographic variables.

The same procedure was used to examine the relative contribution of the relevant predictor variables to variation in Intrinsic and Extrinsic Satisfaction scores.

There were six predictor variables that were significantly associated with Intrinsic Satisfaction: the availability of case managers; the impact of third party payors on treatment relationships; the professionalism of managed care personnel; the influence of third party payors over treatment decisions; reporting family or couples treatment as individual therapy; and selecting a treatment approach to conform with third party reimbursement guidelines. These six variables contributed 25.3% of the variance in Intrinsic Satisfaction scores, after controlling for the contribution of the significant demographic variables.

Finally, the seven variables related to Extrinsic Satisfaction were examined for their unique contribution. The seven variables were: the availability of case managers; the impact of third party payors on the demand for services; the licensure status of managed care personnel, the overall impact of managed care on the practice of psychology; reporting family or couples treatment as individual therapy; selecting a treatment approach to conform with third party reimbursement guidelines; and the impact of peer review processes on patient confidentiality. Taken together, these seven predictor variables accounted for 26.1% of the variation in Extrinsic Satisfaction scores, after controlling for the demographic variables.

Table 36:
Variance Accounted for by Third Party Payor and Managed Care Variables

General Satisfaction	Intrinsic Satisfaction	Extrinsic Satisfaction
25.5%	25.3%	25.7%

Testing of Theoretical Constructs

The relationship between career satisfaction and career planning was examined using independent samples t-tests. The decision to rechoose psychology as a career was significantly related to all three outcome measures: General Satisfaction ($p<.001$); Intrinsic Satisfaction ($p<.01$); and Extrinsic Satisfaction ($p<.001$). Similarly, there was a significant relationship between three outcome measures - General Satisfaction, Intrinsic Satisfaction, and Extrinsic Satisfaction - and changing careers within the next five years ($p<.01$).

Table 37: Theory of Work Adjustment

Variable	General Satisfaction	Intrinsic Satisfaction	Extrinsic Satisfaction
Rechoose Psychology	$p < .001$ $r = -.394$	$p < .01$ $r = -.326$	$p < .001$ $r = -.353$
Change Careers Within Next 5 Years	$p < .01$ $r = .428$	$p < .01$ $r = .383$	$p < .01$ $r = .278$

CHAPTER 4

DISCUSSION

Conclusions

Career Satisfaction

One of the primary objectives of this research was to identify the constructs that were associated with variation in career satisfaction among psychologists. This study made a substantial contribution towards that goal. For this sample, 62% of the total variance in General Satisfaction was explained by the demographic and managed care predictor variables employed in this study.

This study investigated career satisfaction using both global and specific measures. The first global measure - the choice of psychology as a career - has remained fairly stable over the last ten years. In this study, 70% of the practitioners indicated that they would make the same career choice a second time. This proportion is similar to the findings of Norcross and Prochaska (1983) and Norcross, Prochaska, & Farber (1993): Norcross and Prochaska (1983) found that 70% of their sample of members of the APA's Division 29 (Psychotherapy) would rechoose psychology as a career, and Norcross, Prochaska, & Farber's follow-up 1993 study showed that 68% of the Division 29 psychologists in their sample would also select psychology as a career if given the opportunity to rechoose.

The second global measure of career satisfaction was the proportion of psychologists who were planning on changing careers within the next five years. The

results of this study suggest that a growing percentage of practitioners are dissatisfied with their careers. In response to the current survey, 13% of the psychologists indicated that they were planning on changing careers in the near future, compared with only 7% in Norcross, Prochaska, and Farber's 1993 study, a substantial increase in only four years.

One of the secondary objectives of this study was to establish an accurate baseline assessment of career satisfaction among psychologists, using a valid and reliable instrument. Using the Minnesota Satisfaction Questionnaire as the criterion measure, the results of this study reflect a substantial downward trend in career satisfaction among psychologists.

Weiss, Dawis, Lofquist, and England (1967) recommend using percentile scores in interpreting MSQ scores. In their Manual for the Minnesota Satisfaction Questionnaire, high career satisfaction is defined by scores above the 75th percentile, and low satisfaction is indicated by scores below the 25th percentile. Scores in the middle range between the 25th and 75th percentile represent average career satisfaction. The mean General Satisfaction raw score on the MSQ was 75.9, which corresponds to the 45th percentile among employed non-disabled workers. For interpretive purposes, this result places psychologists in the middle of the average range of career satisfaction.

The results of this study can be compared with Norcross, Prochaska, and Farber's 1993 survey of career satisfaction. Although the two studies used slightly

different populations - this study used a random sample drawn from the all the members of the APA, while Norcross and his colleagues surveyed members of APA Division 29 (Psychotherapy) - the groups share sufficient similarities to allow an investigation of broad trends in career satisfaction. Analysis of the percentile scores generated by the current study show that 31% of the practitioners could be classified as highly satisfied with their careers, compared with 47% of the psychologists in the Norcross et al. 1993 sample, which represents a substantial downward trend over a four year period. Similarly, while only 10% of the Norcross et al. sample were dissatisfied with their careers, over 22% of the psychologists in the current study were classified as having low career satisfaction, suggesting a considerable increase in the number of psychologists who are dissatisfied with their careers.

Although these two studies used different sample populations - APA members who are licensed psychologists versus psychologists who are members of APA's Division 29 - the results suggest a very powerful trend, and may represent a substantial change in career satisfaction over a very short period of time. This shift in career satisfaction has coincided with the recent rise of managed care. Is the shift in career satisfaction connected with the increased presence of third parties in the provision of clinical services?

The results of this study provided strong evidence that career satisfaction is linked with managed care. The data revealed that both General Satisfaction and Intrinsic Satisfaction were significantly related to two measures of involvement with

managed care and third party payors: the percentage of income derived from third party payments ($p<.01$ and $p<.001$ respectively), and the proportion of cases that were served under contractual fee-for-services arrangements ($p<.05$ for both General Satisfaction and Intrinsic Satisfaction). Both General Satisfaction and Intrinsic Satisfaction were inversely related to involvement with managed care and third party payors: higher involvement was associated with lower satisfaction.

The relative degree of Intrinsic and Extrinsic Satisfaction is another index of the association between career satisfaction and managed care. If third party involvement is related to career satisfaction, Intrinsic Satisfaction scores should be higher than Extrinsic Satisfaction scores, because managed care is not an essential or inherent aspect of the provision of psychological services. The results of the data analysis provide support for this hypothesis: the difference between these two satisfaction domains was significant at the .0001 level, providing additional support for association between managed care and career satisfaction.

Given the apparent relationship between third party involvement and career satisfaction, what specific aspects of managed care are associated with variations in the respective outcome measures? A number of predictor variables were consistently associated with career satisfaction across the outcome domains of General Satisfaction, Intrinsic Satisfaction, and Extrinsic Satisfaction. Two of the most important predictors concerned professional ethics: reporting family or couples therapy as individual treatment, and selecting a treatment approach on the basis of reimbursement

guidelines. The relative availability of case managers was the third variable connected with all three outcome measures: longer waits were associated with lower levels of career satisfaction.

In addition to these common predictor variables, each of the outcome domains was associated with specific independent variables. General Satisfaction was related to three predictors: the impact of third party payors on the treatment relationship; the influence of third party payors over treatment decisions; and the licensure status of utilization review personnel. Intrinsic Satisfaction was also associated with the impact of third party payors on the treatment relationship and the influence of third party payors over treatment decisions, as well as the professionalism of managed care personnel. Finally, Extrinsic Satisfaction was linked with the licensure status of utilization review personnel, the overall impression of the impact of managed care on the practice of psychology, the potential for peer review to compromise patient confidentiality, and the impact of third party payors on the demand for the practitioners' services.

The most remarkable finding was the relative strength of the ethics items in predicting satisfaction scores. Without question, the ethics items were the most powerful predictors across all three domains of career satisfaction. Adding the two ethics items to the General Satisfaction regression equation increased the explained variance from 15% to 41%. The same trend was evident in the other two outcome domains: including the ethics items in the Intrinsic Satisfaction equation raised the

explained variance from 12% to 31%, and adding the three ethics variables to the Extrinsic Satisfaction equation led to an increase in explained variance from 16% to 35%.

The ethics questions revealed a number of interesting trends. First, the *incidence* of ethical dilemmas was not related to any of the outcome measures. Instead, it was the practitioners' *reactions* to the occurrence of ethical dilemmas that predicted career satisfaction. As might be expected, psychologists felt most comfortable in giving patients less severe diagnoses. On the other hand, practitioners were most distressed with giving patients less treatment than they required.

The results of the study showed that providing psychological services in the current business environment is frequently associated with ethical compromise. These results are even more striking when one considers that endorsing the questionnaire items implied that the respondent was violating the APA Code of Ethics, as well as state laws concerning insurance fraud. The percentages are alarming: 60% of the psychologists in the survey reported giving patients *more* severe diagnoses than were warranted by the presenting symptomology, in order to comply with reimbursement guidelines and obtain services for their clients. The impact of a severe psychological diagnosis in a medical record should not be underestimated: in the event that a patient decides to change insurance plans, or is required to make a shift due to a change in jobs, diagnostic exclusions may prevent the patient from obtaining health care coverage. In addition to deliberate misdiagnosis, 70% of the psychologists in the study

have reported family or couples therapy as individual treatment, and 79% of the practitioners indicated that they had given less treatment than patients required, due to reimbursement guidelines. The prevalence of ethical violations and the high incidence rate of misrepresentation of treatment among practitioners provide strong evidence that psychologists are being forced into untenable positions by systemic forces. Ethical violations are inevitably detrimental to the profession: the question remains whether psychology can survive a situation where practitioners routinely violate their own ethical code.

Gender and Career Satisfaction

There was a significant difference in General Satisfaction between the male and female psychologists in the study ($p<.01$): the results indicated that male practitioners are more satisfied than their female counterparts. Further investigation using analysis of variance indicated that gender was significantly associated both with the scores on the Extrinsic Satisfaction scale ($p<.001$), and with the responses to the seven item constellation of questions concerning satisfaction with managed care ($p<.01$). Once again, male practitioners were more satisfied than female practitioners. Overall, there was no apparent difference between male and female participants in terms of Intrinsic Satisfaction scores.

Several different hypotheses may be advanced to explain these differences. One explanation may be that women have a more negative reaction to managed care. This proposition was supported by fact that the female psychologists in the study had a

significantly more negative evaluation of the impact of managed care on the practice of psychology ($p<.01$). In addition, the women in the sample had a stronger reaction to the licensure status of utilization review personnel ($p<.01$) and the potential negative impact of peer review on patient confidentiality ($p<.01$). Finally, the female respondents did not experience the same degree of collaboration with case managers ($p<.05$): they indicated that it took longer for them to have their messages returned ($p<.05$) and receive authorization for services ($p<.05$).

An alternative explanation of the difference in career satisfaction between male and female psychologists can be found in the demographic variables. In particular, the female psychologists in the study had been in the profession for a significantly shorter period of time compared with male practitioners ($p<.01$). Although there was no direct measure of individual income generated by their practices, the female practitioners in the survey reported that they relied more heavily on the income generated by their practice ($p<.001$), even though their earnings contributed a smaller percentage towards the total family income ($p<.01$). Similarly, the female psychologists indicated that they spent less time performing reimbursable tasks, compared with the males in the sample ($p<.001$). Though the discrepancy in income may be an artifact of the disparity in the amount of time that the respondents have been involved in delivering psychological services, the differences between the two groups suggest that the female respondents felt that they were under more pressure than the males to produce income. The strain of greater perceived responsibility for

financial security, coupled with their relatively reduced earning power, may have led to lower levels of career satisfaction among female practitioners.

Theory of Work Adjustment

The study provided considerable evidence supporting the Theory of Work Adjustment. Rounds, Dawis, and Lofquist (1987) examined the relative contributions of occupational reinforcer patterns and worker needs to career satisfaction. The results showed that occupational reinforcers were more important than individual needs in predicting career satisfaction. After establishing the relative strength of reinforcers, patterns of specific occupational reinforcers were assessed along three dimensions: reinforcer elevation, a measure of the strength of a specific reinforcer; scatter; and profile shape, which captured the presence, rather than the degree, of the reinforcer. After examining the three different dimension of occupational reinforcers using multiple regression analysis, the authors concluded that profile shape was the most effective predictor of career satisfaction.

The salient profile shape of reinforcers for counseling psychologists and clinical psychologists included the following elements: 1) altruism (the opportunity to benefit other people through their work, as well as the chance to perform their work-related duties without feeling that they are morally wrong); 2) autonomy (the freedom to try out their own ideas, make decisions on their own, and carry out their work without a great deal of supervision; and 3) achievement (the opportunity to make use of their individual abilities and gain a sense of accomplishment).

The results of the study are consistent with predictions based on the theory. The data showed that General Satisfaction was significantly related to variables that corresponded with the three key occupational profile reinforcers: altruism, autonomy, and achievement. Work Adjustment Theory and subsequent research suggested that altruism, or doing work without feeling that it was morally wrong, was important for psychologists. This study provided evidence that ethics variables were the single most important predictor of career satisfaction. Similarly, the research literature indicated that autonomy, which included making their own decisions and trying out their own approaches, were important reinforcers for psychologists. These predictions were also confirmed by the data this from study, which showed that General Satisfaction was significantly related both to third party payors' influence over treatment decisions ($p<.05$), and to selecting treatment approaches to conform with third party reimbursement guidelines ($p<.01$).

Finally, the Practice of Psychology Survey generated data on practitioners' satisfaction with specific aspects of managed care (items B-29 through B-35 on the questionnaire). The last item, B-35, concerned psychologists' satisfaction with the acknowledgment that they received from case managers and utilization review personnel, and served as an index of the final occupational reinforcer: achievement. The average scores for this item revealed that practitioners were dissatisfied with the acknowledgment that they received from case managers, and subsequent data analysis

showed that this achievement reinforcer was also significantly related to General Satisfaction ($p<.05$; $r=.25$).

Finally, this study also generated support for one of the propositions associated with Work Adjustment Theory. Proposition VII (Weiss, Dawis, England, & Lofquist, 1967) predicts that the probability of changing work environments is inversely proportional to the workers' degree of satisfaction. Inspection of the data using analysis of variance showed that General Satisfaction was strongly related to planned career change ($p<.0001$).

Limitations

While limitations in any research endeavor are unavoidable, this study took steps to minimize the threats to validity through the use of random sampling and an adequately sized sample. While the survey sample corresponded well with the general demographic characteristics of the membership of the APA, caution should be used in generalizing the results.

Although this study was designed to be comprehensive, it must be acknowledged that career satisfaction is a complex construct. The process of research is one of incremental improvements: all models, and all conclusions, will always be incomplete. Consequently, the correlational nature of this research must be emphasized: although the study found that third party payor and managed care variables were associated with career satisfaction, it did not establish that those predictors were responsible for causing the variation in career satisfaction scores.

It should be recognized that there are alternative explanations for the results of this study. Practitioner dissatisfaction may in fact stem from personal characteristics, and not from outside institutional forces. For example, psychologists have traditionally been independent operators, and have become accustomed to developing their own standards of practice. The new marketplace has changed the nature, and the source, of professional standards of practice. Membership on managed care panels may result in practitioners being held to expectations that reflect the priorities of a corporate culture. Psychologists who were not accustomed to the imposition of standards by outside forces must now accept that they are accountable to third parties, in addition to their clients and their peers. The low levels of career satisfaction reported by many practitioners in this study may be a reflection of their unwillingness to change in the face of these new demands and new environments.

Despite the attempts to avoid limitations, a number of methodological shortcomings remain. Although the total return rate of 28% was comparable to the 33% response rate of the APA CAPP study, it falls short of complete participation by all the subjects in the sample pool. Consequently, self-selection may have played a role in the determination of the results. Similarly, both of the instruments in the study were self-report measures, and may have suffered from the effects of deliberate or accidental errors by the respondents. In addition, although the inclusion of questions in the Study on the Practice of Psychology survey was based on previous

questionnaires and relevant research, the reliability and validity of the instrument remain uncertain.

Because this study attempted to gain a thorough understanding of the factors that influenced career satisfaction among psychologists, the survey incorporated a large number of variables. Assessing the relationships among these variables entailed a large number of tests. Although the amount of testing was kept to a minimum through the use of multiple regression and ANOVAs, Type I error remains a possibility.

The Minnesota Satisfaction Questionnaire contained a number of limitations. The construction of the instrument reflected its original purpose, which was to assist career counselors in assessing current career satisfaction. The design team identified twenty items that contributed to career satisfaction. The twenty items of the General Satisfaction scale were entered into a factor analysis, and then partitioned into two subscales: Intrinsic Satisfaction, with 14 items, and Extrinsic Satisfaction, which had 6 items. This arrangement appeared to meet the career counselor's need for an omnibus satisfaction assessment tool.

Unfortunately, the distribution of the items into uneven subscales resulted in an arbitrary weighting, which favored the Intrinsic Satisfaction scales. Due to the 2:1 disparity in the number of subscale items, reinforcer items that correspond with the inherent aspects of a career exert a disproportionate leverage on the General Satisfaction scale. Conversely, the limited number of items in the Extrinsic Satisfaction scale make it difficult to detect changes in General Satisfaction due to external factors.

The unequal distribution of items into their respective scales may have created an instrumentation artifact that affected the outcome of the study. Managed care and third party interactions are external - they are not an inherent aspect of providing psychological services. As such, they would naturally fall into the realm of Extrinsic Satisfaction. However, the limited number of items in that scale made it difficult for managed care and third party variables to exert an influence over General Satisfaction scores.

This limitation was especially relevant to this study, because 41% of the respondents identified themselves as solo independent practitioners. Because they are self employed, these practitioners could not answer items 5 and 6 on the MSQ, which concern the respondents' relationships with their "boss" or supervisor. Leaving out responses on these two items reduces the Extrinsic Satisfaction scale to four questions, creating a considerable barrier to the assessment of the role of managed care and third party payors on General Satisfaction.

The potential impact of the unequal scales on the results of this study can be estimated by modifying the Extrinsic Satisfaction scale to reflect the nature of the research population. The modification began by investigating average scores on the MSQ Extrinsic Satisfaction scale and the seven items on the Study on the Practice of Psychology (SPP) that corresponded to satisfaction with managed care. A paired sample t-test showed that the average scores on the two sets of questions were significantly different at the .0001 level.

The MSQ Extrinsic Satisfaction scale was expanded by including four questions specifically relating to managed care: B-29, which concerned practitioner satisfaction with the competence of case managers and UR personnel; B-30, which addressed the professionalism of case managers and UR personnel; B-31, which assessed the management skills of case managers and UR personnel; and B-35, which gauged the practitioners satisfaction with the amount of acknowledgment that they received from case managers and UR personnel for doing their job well.

Factor analysis revealed a three factor solution. The first two factors corresponded exactly to the content items of Extrinsic Satisfaction scale, and contained two items related to supervisors (MSQ questions 5 and 6) and four items concerning pay, company policies, chances for advancement, and praise for doing a job well (MSQ questions 12, 13, 14, and 19). The third factor corresponded precisely to the additional four items from the Study on the Practice of Psychology (SPP). None of the SPP items loaded above .25 on the MSQ factors, and none of the MSQ items loaded above .25 on the SPP factor.

A regression analysis was performed on the managed care variables, with two new outcome variables: 1) the modified extrinsic satisfaction scale, which included the four additional questions related to satisfaction with managed care; and 2) a new general satisfaction scale, which reflected the changes in the modified extrinsic satisfaction scale. The analysis found three additional managed care variables that

were significantly related to general satisfaction, and five more managed care predictor variables that were significantly linked to extrinsic satisfaction.

Finally, the construction of the MSQ does not lend itself to the resolution of a vital question: which is more important in determining overall career satisfaction - Intrinsic Satisfaction or Extrinsic Satisfaction? In addition, the MSQ does not address the relationship between demographic factors (e.g. age or income) and career satisfaction. These shortcomings suggest that the MSQ may benefit from a revision. Future researchers may also want to consider modifying the MSQ to reflect the specific characteristics of their sample pool.

Implications

Directions for Future Research

While this study answered a number of questions related to career satisfaction among psychologists, several important issues remain. This study clarified the relationship between managed care and career satisfaction, but it did not address the relative importance of intrinsic versus extrinsic satisfaction in determining the overall career satisfaction among psychologists. In addition, the results of this study showed that several aspects of managed care involvement were related to Intrinsic Satisfaction, suggesting that the dividing line between Intrinsic and Extrinsic satisfaction may not be a function of the apparent inherent or external nature of the source of the satisfaction. Further research may help to clarify these definitions.

The relationship between Intrinsic Satisfaction and managed care variables suggests that third party involvement may have an impact on the satisfaction that practitioners derive from the provision of psychological services. This hypothesis is counter-intuitive: by definition, Intrinsic Satisfaction should be limited to those aspects of a job that are inherently involved in its performance.

Certainly, the prospect of outside systemic forces gradually eroding the satisfaction that psychologists obtain from providing therapy has significant implications for the future of the profession. For example, negative experiences associated with specific managed care organizations or third party payors may result in psychological service providers treating patients enrolled in those programs differently. Frustrations with required documentation or delays in reimbursement may start to intrude on the client-practitioner relationship, and have a negative impact on the outcome of therapy. A future study examining the relationship between practitioners' satisfaction with managed care or third party payors and therapeutic outcomes would help to clarify the impact of third party payors on patient care.

Potential Avenues of Change

It is important to acknowledge that the introduction of managed care techniques represented an opportunity for the mental health care field. The changes brought about by managed care had the potential to be either positive or negative. In theory, there were a number of different ways that managed care could have transformed the delivery of psychological services, and those changes could easily

have been beneficial. It is also important to acknowledge that managed care is a new technology, one that is its formative stages, and still subject to growth and modification as a natural part of the developmental process. The challenge facing the health care industry, and the practice of psychology in particular, is to participate in shaping future developments in managed care so that they reflect the best interests of the patient.

The problems posed by third party payors will not disappear - the proportion of psychological services under managed care continues to grow. According to Adelson (1997), 65 million Americans receive their health care from HMOs. Working with managed care has become an inescapable reality for many practitioners. If psychologists wish to change the environment in which they practice, and thereby improve their level of career satisfaction, they will have to begin to attend to the political, social, and economic forces that have an impact on their practice (Austad, 1992).

Legislative Initiatives

In the 1980's, the conventional wisdom held that market forces, and not government regulation, should determine the shape of the health care system (Cummings, 1986). Changes in health care delivery and the standard of care over the last decade have led to a call for legislation to control managed care (Bowers & Knapp, 1993; Seppa, 1997). Prior to 1990, there were no laws governing the practice of psychology in managed care settings (Newman & Bricklin, 1990). The situation has begun to change: Sleek (1996a) reported that five states, including California and

Virginia, now have laws governing the utilization review process. Psychologists are beginning to coordinate their activities with other health-care advocacy groups, in an attempt to change the way health care is delivered. The APA has joined with a number of other groups to form the Coalition for Fairness in Mental Illness Coverage (Sleek, 1996b). The purpose of the coalition is to continue lobbying for patient rights in Congress. The group has achieved some notable success already: Congress recently decided to ban annual and lifetime dollar caps on mental health care insurance benefits.

Judicial Initiatives

In addition to promoting change in managed care practice through legislative initiatives, psychologists are also beginning to use the judicial system to remedy some of the problems that are associated with working in managed care systems. Sleek (1997) reported that a group of seven New Jersey psychologists have filed a landmark class action suit against a managed mental health care company, in an attempt to regain some measure of power over clinical decision-making. While progress is being made, sweeping change is not likely in the near future. Instead, psychologists will have to accept incremental shifts in the way that services are provided (Sleek, 1996a).

Proactive Participation

Psychologists can begin to take a number of actions in addition to legislative and judicial initiatives. Berkman, Bassos, and Post observed that, "Mental health professions can best be served if mental health professionals do not abdicate their

responsibility and leadership to those people who are primarily experienced and trained in the business aspects of health care." (1988, p. 436). Flinn, McMahon, and Collins (1987) reported that only 45% of all HMOs have a mental health director, and only 60% of the those mental health directors were psychologists or physicians. For current managed care practices to change, psychologists need to participate in the process, and take a more active role in designing benefits packages and delivery systems for managed mental health care organizations (Zimet, 1989).

Ethics

The results of this study indicate that practitioners are routinely experiencing ethical dilemmas in the course of providing psychological services within managed care contexts. Unfortunately, the APA Code of Ethics (1990) and the General Guidelines for Providers of Psychological Services (1987) do not make any specific references to managed care, and therefore cannot provide any clear direction for practitioners. Newman and Bricklin (1991) observed that the current APA guidelines for providers may require psychologists to take responsibility for situations over which they have no control. For example, the Ethics Code prevents psychologists from abandoning patients. However, what are the psychologists' responsibilities when a third party payor prematurely terminates therapy as a result of financial considerations? Seventy percent of the psychologists who participated in this study reported that they had given less treatment than a patient required due to third party reimbursement guidelines. For most psychologists, the alternative to abandonment is an increasing

percentage of clients who are seen on a *pro bono* basis. Unfortunately, that solution is limited: extrapolated over months or years, it can result in an entire caseload of *pro bono* patients, a situation which is financially untenable.

Psychology as a profession must begin to grapple with the question of how to respond to a situation that forces its members to contravene its own ethical code. The question is difficult, for it implies a fundamental decision: should psychologists attempt to change the circumstances and forces that lead to ethical dilemmas, or should they adapt their ethics to meet the realities of the marketplace? Historically, the APA has taken a leadership position in establishing a model code of ethics that serve as an example for all professions. If psychologists are to determine their own professional code of appropriate behavior, the APA must move quickly to revise its Ethical Code to reflect the challenges presented by managed care.

Education

The involvement of third party payors in the clinical decision-making process has had an enormous impact on the provision of psychological services. The climate and the environment have changed profoundly. Unfortunately, many psychologists are not equipped to face the realities of these shifts in the delivery of mental health care. Some of the lack of preparation may be traced to the current system of training psychologists. Many authors agree that graduate schools do not prepare psychologists for the realities of working in a managed care environment (Austad, 1992; Hoyt, 1992;

Nahmias, 1992; Walfish, Moritz, & Stenmark, 1991) or in pre-paid capitated systems (Bennett, 1988).

Much of the current focus on changing the curriculum of graduate school training is centered on the relationship between clinical and counseling psychology, and on improving the technical skills of student psychologists. The results of this study suggest that future practitioners must also be trained in the pragmatic aspects of delivering psychological services in managed care contexts. Future students will benefit from more extensive coursework in the identification and resolution of ethical dilemmas related to third party payors and managed care. Students will also need to develop a sound theoretical knowledge of the fundamentals of brief therapy, and be able to demonstrate their proficiency with these models in practicum settings.

In order to be successful in the current marketplace, practitioners must be able to substantiate the efficacy of their interventions. This mandate is consistent with the traditional scientist-practitioner model of psychology, in which theory and practice are informed by research. The skills of the scientist-practitioner model are indispensable, and adequate training in the future should include a balanced curriculum, one that continues to emphasize both research and practical application.

APPENDICES

APPENDIX A

APPENDIX A

GLOSSARY

HMO:

"An HMO is a health care system that provides comprehensive outpatient and hospital services (including mental health services) for enrolled members for a fixed, pre-paid annual fee through a single payment mechanism." (Bloom, 1990: p. 110)

Staff HMO:

"In a staff model HMO, providers are salaried employees who work regular hours (usually in specified location) and are not involved in financial risk sharing." (Austad & Sherman, 1992: p. 3)

Group HMO:

"A group of physicians, usually a partnership or separate corporation, contracts to provide necessary services on a capitated basis" (Bennett, 1988: p. 1546)

Managed mental health care organization (MMHCO):

"A managed mental health care organization provides comprehensive outpatient and inpatient mental health services usually including treatment services for alcohol and drug abuse using a variety of reimbursement models. The MMHCO usually contracts with employers, insurers, or even HMOs to provide a specified set of services to their covered employees or subscribers through a fixed prepaid fee, or through a network of fee-for-service mental health professionals whose efforts at cost containment may include a variety of UR procedures." (Bloom, 1990, p. 111)

Payor:

The party, usually insurers, that reimburses providers for services.

Preferred provider organization (PPO):

"In Preferred Provider Organizations (PPO) payers purchase health care services from selected providers, at a discount. The provider receives an increased volume of patients in exchange for discounted fees. Providers keep their fee-for-service billing but with a fee discount to attract new business and are not at risk." (Austad & Sherman, 1992, p. 4)

Providers:

Professional medical or mental health practitioners

Purchaser:

The individual or corporation that buys a package of health care benefits from an HMO or insurer.

APPENDIX B

APPENDIX B

SAMPLE: STUDY ON THE PRACTICE OF PSYCHOLOGY

Please answer all questions as thoroughly and accurately as you can. The information that you provide will contribute to a more comprehensive understanding of the current nature of the practice of psychology. All replies to this questionnaire will remain anonymous. If you have any questions, or would like any further information, please contact Brooke Stevens, Kirby Hill, Jericho, New York 11753; (516) 921-4818.

Directions: Please answer questions by marking the space to the left of the appropriate response. If you work in more than one environment, your responses should reflect your primary practice, or the setting where you spend the majority of your professional time.

Do you spend at least twenty hours per week providing psychological services? (Psychological services are defined as direct client or patient contact, providing individual, conjoint, family, or group psychotherapy, counseling, or assessments)

_____ Yes
_____ No

If your answer is Yes, go to question A-1. If your answer is No, you do not need to proceed further. Please return this questionnaire in the envelope provided. Thank you!

SECTION A - DEMOGRAPHIC INFORMATION

A-1. In what year were you born?

19 _____

A-2. What is your gender?

_____ Male
_____ Female

A-3. What is your racial/ethnic background?

_____ Black/African American
_____ Alaska Native/American Indian
_____ Asian/Pacific Islander
_____ Caucasian
_____ Hispanic American
_____
Other:_____

A-4. In what year did you receive your Doctorate?

19 _____

A-5. Since receiving your Doctorate, how many years have you worked at least twenty hours per week (or its equivalent) providing psychological services?

_____

A-6. How many wage earners contribute to your family's income? (Count yourself as one.)

_____

A-7. What was your family's total annual income for 1995? (Include income from all sources, e.g. rental income, investments, child support, alimony, etc.)

_____ Less than $25,000
_____ $25,000 - $39,000
_____ $40,000 - $59,000
_____ $60,000 - $79,000
_____ $80,000 - $99,000
_____ $100,000 - $119,000
_____ $120,000 - $139,000
_____ Over $139,000

A-8. What percent of your family's total annual income for 1995 was derived from your professional practice?

_____ %

A-9. To what extent does your household depend on your income from your professional practice?

_____ Essential
_____ Important, but not essential
_____ Helpful, but not important
_____ Negligible contribution

A-10. If you had to choose a career over again, would you choose psychology?

_____ Yes
_____ No

A-11. Are you planning on changing careers and leaving the field of psychology within the next five years?

_____ Yes
_____ No

SECTION B - PRACTICE INFORMATION

B-12. In what type of community do you practice?

_____ Urban
_____ Suburban
_____ Rural

B-13. What is your primary work setting?

_____ Solo independent practice
_____ Group independent practice
_____ Staff HMO
_____ Group HMO
_____ Community Mental Health facility
_____ Government facility
_____ Medical facility

B-14. What percentage of your work time is devoted to the following tasks:

_____ % Psychotherapy or direct service provision
_____ % Billing
_____ % Utilization Review/Documentation
_____ % Other _____

B-15. What is the average amount of time that you work each week? (both billable and non-billable time)

_____ Billable hours
_____ Non-billable hours

B-16. If you have a solo independent practice, or are part of a group independent practice, what are your customary fees for each of the following? (If not applicable, enter zero.)

$ _____ Individual psychotherapy (50 minutes)
$ _____ Couples therapy (50 minutes)
$ _____ Family therapy (50 minutes)
$ _____ Group therapy (1 1/2 hours)
$ _____ Diagnostic evaluation (50 minutes)

This section (B-17 through B-28) relates to your current caseload; please answer all questions. If it would be helpful, please feel free to refer to your appointment book or files.

B-17. How many cases make up your current caseload? (Count each member of a group as one case. Count couples and families, if the members are primarily seen together, as one case.)

_____

B-18. Is you caseload primarily (check one only):

_____ children
_____ adolescents
_____ adults

B-19. Please estimate the percentage your current caseload that is:

_____ % Male
_____ % Female

B-20. Please estimate the percentages of your current caseload that are in the following groups:

_____ % Black/African American
_____ % Alaska Native/American Indian
_____ % Asian/Pacific Islander
_____ % Caucasian
_____ % Hispanic American
_____ % Other: _____

B-21. Please estimate the percentages of your current active caseload that are:

_____ % White collar (accountants, attorneys, managers, physicians, administrators, computer specialists, teachers, personnel specialists)
_____ % Blue collar (mail carriers, skilled laborers, stock handlers, warehouse workers)
_____ % Students, or those not currently in labor force by choice (women who are currently staying at home, retirees)
_____ % Unemployed (not fitting category 3)

B-22. Please estimate the percentage of your cases that pay at the following rates:

_____ % Full rate
_____ % Reduced rate (including PPO discounts and sliding scale fees)
_____ % Free

B-23. Please estimate the proportion of your cases that require prior approval of treatment plans by a third party before payment for services is approved:

_____ %

B-24. Please estimate the proportion of your cases in which a third party payer determines the specific treatment modality (e.g. individual, family, group) before services are provided:

_____ %

B-25. Please estimate the proportion of your cases that use the following types of funding sources to pay for services that you provide: (Please choose only one funding source for each client in your caseload. If a family or couple is treated, include all the individuals in the unit under the appropriate funding source. Choose the most appropriate source, even if co-payments are made by the client.)

_____ % Fee-for-service
_____ % Contractual fee-for-service (i.e., Medicare or Medicaid, PPO)
_____ % Capitated

B-26. Which of the following approaches do you currently utilize? (check all that apply)

☐ Behavioral
☐ Client-centered
☐ Cognitive/behavioral
☐ Ego psychology
☐ Gestalt
☐ Humanistic
☐ Psychodynamic/Psychoanalytic
☐ Systemic
☐ Other (please specify) _____

B-27. Which of the following approaches were emphasized in your original training? (check all that apply)

☐ Behavioral
☐ Client-centered
☐ Cognitive/behavioral
☐ Ego psychology
☐ Gestalt
☐ Humanistic
☐ Psychodynamic/Psychoanalytic
☐ Systemic
☐ Other (please specify) _____

B-28. Have you had to change your theoretical orientation in order to stay on provider panels?

_____ Yes
_____ No

The following section (B-29 through B-35) refers to interactions with third party payors or managed care. Please use the scale below to indicate your level of satisfaction:

1 Highly satisfied	2 Satisfied	3 Neither satisfied nor dissatisfied	4 Dissatisfied	5 Very Dissatisfied	6 Not Applicable

B-29. _____ The competence of utilization review personnel or case managers:

B-30. _____ The professionalism of utilization review personnel or case managers:

B-31. _____ The management skills of utilization review personnel or case managers:

B-32. _____ Your working relationship with utilization review personnel or case managers:

B-33. _____ Your ability to use your own judgment in clinical matters:

B-34. _____ The opportunity to use your own treatment approaches:

B-35. _____ The acknowledgment you receive from utilization review personnel or case managers for doing your job well:

SECTION C - THIRD PARTY PAYORS

Please check the space to the left of the appropriate answer. Note: "Third party payors" refers to insurance companies, HMO's, PPO's, or managed care firms, who pay you for all or part of your services to clients.

C-36. To what extent do you depend on referrals from third party payors to maintain your caseload?

_____ Not at all
_____ Very little
_____ Moderately
_____ Greatly
_____ Not applicable

C-37. What impact has working with third party payors had on the demand for your services?

_____ Greatly increased your caseload
_____ Moderately increased your caseload
_____ No impact on your caseload
_____ Moderately decreased your caseload
_____ Greatly decreased your caseload

C-38. What type of impact have third party payors had on the development of treatment relationships?

_____ Highly positive
_____ Moderately positive
_____ None at all
_____ Moderately negative
_____ Highly negative

C-39. What effect does the involvement of third parties have on the overall quality of treatment that you provide?

_____ Highly positive
_____ Moderately positive
_____ None at all
_____ Moderately negative
_____ Highly negative

C-40. Are guidelines for third party reimbursement a consideration in your choice of diagnosis?

_____ Not at all
_____ Very little
_____ Moderately
_____ Greatly
_____ Not applicable

C-41. Do you feel any pressure to adjust your treatment decisions in order to stay on provider panels with PPO or HMO contracts?

_____ Not at all
_____ Very little
_____ Moderate
_____ Great
_____ Not applicable

C-42. Does the acceptance of third party funds create dilemmas for you when making case decisions?

_____ Not at all
_____ Very little
_____ Moderately
_____ Greatly
_____ Not applicable

This section (C-43 through C-56) relates to your current caseload as reported in question B -15. If it would be helpful, please feel free to refer to your appointment book or files.

C-43. How often were cases given a less severe diagnosis in order to conform with third party reimbursement guidelines?

_____ Never
_____ Rarely
_____ Occasionally
_____ Frequently
_____ Not Applicable

C-44. If you have used a less severe diagnosis in order to conform with third party reimbursement guidelines, were you:

_____ Comfortable with the decision
_____ A little uncomfortable
_____ Moderately uncomfortable
_____ Considerably disturbed
_____ Greatly disturbed
_____ Not Applicable

C-45. How often were cases given a more severe diagnosis in order to conform with third party reimbursement guidelines?

_____ Never
_____ Rarely
_____ Occasionally
_____ Frequently
_____ Not Applicable

C-46. If you have used a more severe diagnosis in order to conform with third party reimbursement guidelines, were you:

_____ Comfortable with the decision
_____ A little uncomfortable
_____ Moderately uncomfortable
_____ Considerably disturbed
_____ Greatly disturbed
_____ Not Applicable

C-47. How often were cases reported as individual treatment in order to conform with third party reimbursement guidelines, when other treatment (such as conjoint or family) was provided?

_____ Never
_____ Rarely
_____ Occasionally
_____ Frequently
_____ Not Applicable

C-48. If you have reported a case as individual treatment in order to conform with third party reimbursement guidelines, when other treatment was provided, were you:

_____ Comfortable with the decision
_____ A little uncomfortable
_____ Moderately uncomfortable
_____ Considerably disturbed
_____ Greatly disturbed
_____ Not Applicable

C-49. How often was the modality of treatment selected in order to conform with third party reimbursement guidelines, when another treatment modality was warranted (for example, providing group therapy, when individual treatment might have been more appropriate)?

_____ Never
_____ Rarely
_____ Occasionally
_____ Frequently
_____ Not Applicable

C-50. If you have selected a treatment modality in order to conform with third party reimbursement guidelines, were you?

_____ Comfortable with the decision
_____ A little uncomfortable
_____ Moderately uncomfortable
_____ Considerably disturbed
_____ Greatly disturbed
_____ Not Applicable

C-51. How often was a treatment approach selected in order to conform with third party reimbursement guidelines, when another treatment approach would have been more appropriate (for example, providing brief or task-oriented treatment, when your knowledge or experience suggested another choice)?

_____ Never
_____ Rarely
_____ Occasionally
_____ Frequently
_____ Not Applicable

C-52. If you have selected a treatment approach in order to conform with third party reimbursement guidelines, when you considered another treatment approach more appropriate, were you:

_____ Comfortable with the decision
_____ A little uncomfortable
_____ Moderately uncomfortable
_____ Considerably disturbed
_____ Greatly disturbed
_____ Not Applicable

C-53. How often was a client given less treatment than the client needed in order to conform to third party reimbursement guidelines?

_____ Never
_____ Rarely
_____ Occasionally
_____ Frequently
_____ Not Applicable

C-54. If you have given less treatment than the client needed in order to conform to third party reimbursement guidelines, were you:

_____ Comfortable with the decision
_____ A little uncomfortable
_____ Moderately uncomfortable
_____ Considerably disturbed
_____ Greatly disturbed
_____ Not Applicable

C-55. The peer review processes which are used by insurance companies:

_____ Enhance confidentiality
_____ Have no effect on confidentiality
_____ Have the potential for breaches in confidentiality
_____ Occasionally jeopardize confidentiality
_____ Greatly jeopardize confidentiality

C-56. Do you feel that you, as the therapist, are the agent of:

_____ The patient
_____ The purchaser of the health care, including employers
_____ The payor, if different from the patient or purchaser
_____ Both the patient and the payor
_____ The patient, the purchaser, and the payor

SECTION D - MANAGED CARE

This section refers to your interactions with managed care organizations. If you have business contacts with more than one managed care company, please choose the response that best represents the majority of your interactions.

D-57. Please rate your ease in contacting managers:

_____ Readily available, with minimal wait time
_____ Occasional (20% or less) waits over 10 minutes - usually less
_____ Waits over 10 minutes between 20% to 50% of the time
_____ Waits over 10 minutes over 50% of the time
_____ Long waits typical

D-58. Please indicate the time it takes for managers to return messages (voice mail etc.):

_____ Promptly, within a few hours
_____ Nearly always within 24 hours
_____ Usually within 24 hours, occasionally longer
_____ Over 24 hours 20% to 50% of the time
_____ Over 24 hours 50% of the time, or not returned at all

D-59. Please indicate the timeliness that you experience in obtaining authorization for emergency services, medical consults, and ancillary services:

_____ Promptly, within a few hours
_____ Nearly always within 24 hours
_____ Usually within 24 hours, occasionally longer
_____ Usually within 48 hours
_____ Usually over 48 hours

D-60. Please indicate the amount of time that it takes for you to receive authorization for treatment (from the time you mail or call in your request until you receive a written or verbal authorization):

_____ Within 1 week
_____ Usually within one week, occasionally longer
_____ Nearly always within 2 weeks
_____ Occasionally longer than 2 weeks
_____ Usually longer than 2 weeks

D-61. In general, what is the average number of sessions that you request from managed care companies:

_____

D-62. After how many sessions do you usually have to apply for reauthorization?

_____

D-63. Please indicate your experience with managers when you request reauthorization:

_____ Dialogue reasonable and appropriate
_____ Justification required but accepted
_____ Sessions granted or denied without justification
_____ Difficulty obtaining more sessions
_____ Managers contentious and rigid

D-64. Please indicate the extent to which the manager collaborates with you throughout the course of a case:

_____ Collegial and constructive
_____ Usually collegial and constructive
_____ Occasionally collegial and constructive
_____ Occasionally adversarial and non-constructive
_____ Adversarial and non-constructive

D-65. Please rate the professionalism of the managers of the companies that you work with most often:

_____ Highly professional
_____ Professional
_____ Adequate
_____ Occasionally unprofessional
_____ Unprofessional, lacking knowledge or skill.

D-66. Does it concern you that utilization review personnel employed by insurance or managed care companies are often non-psychologists?

_____ No concern
_____ Small amount of concern
_____ Moderate amount of concern
_____ Considerable distress
_____ Profound distress

D-67. Utilization review personnel or case managers use criteria that are:

_____ Written, in clear and concise terms.
_____ Unwritten - but policy is clear and consistent.
_____ Unwritten - but policy is unclear and inconsistent.
_____ There are no stated criteria, either verbally or in writing.

D-68. When working in a managed care context, how much control do you feel you exert over clinical decisions?

_____ Strong control
_____ Moderate amount of control
_____ Some control
_____ Hardly any control
_____ No control at all.

D-69. Please indicate the average promptness of payment after billing:

_____ Within 30 days
_____ Between 30 and 60 days
_____ Usually between 30 and 60 days, occasionally longer
_____ Usually between 60 and 90 days, occasionally longer
_____ Usually longer than 90 days

D-70. What proportion of your total annual income from professional practice depends on third party payments?

_____ Less than 20%
_____ Between 20% and 40%
_____ Between 41% and 60%
_____ Between 61% and 80%
_____ Over 80%

D-71. Overall, what is your opinion of the impact of managed care on the practice of psychology?

_____ Marked improvement in services
_____ Moderate improvement in services
_____ No influence on services
_____ Moderately adverse influence on services
_____ Marked adverse influence on services

Thank you very much for your participation!

Please place the completed forms in the stamped and addressed envelope and return them to:

Brooke L. Stevens, M.S.
Kirby Hill
Jericho, NY 11753

APPENDIX C

APPENDIX C

ITEM KEY: STUDY ON THE PRACTICE OF PSYCHOLOGY QUESTIONNAIRE

DEM	STR	M/C	ETH	COM	FIN
A-1	B-12	C-38	C-43	D-58	B-16
A-2	B-13	C-39	C-44	D-59	C-36
A-3	B-14	C-40	C-45	D-60	C-37
A-4	B-15	C-41	C-46	D-61	D-64
A-5	B-17	C-42	C-47	D-67	D-69
A-6	B-18	D-61	C-48		D-70
A-7	B-19	D-62	C-49		
A-8	B-20	D-63	C-50		
A-9	B-21	D-64	C-51		
B-26	B-22	D-65	C-52		
B-27	B-23	D-66	C-53		
B-28	B-24	D-68	C-54		
	B-25	D-71	C-55		

APPENDIX D

APPENDIX D

SAMPLE: COVER LETTER

Brooke L. Stevens, M.S.
Kirby Hill
Jericho, NY 11753

November 15, 1996

Dear prospective participant,

The practice of psychology has undergone a number of changes in the past ten years. My dissertation will look at the current structure of the practice of psychology, as well as the satisfaction that psychologists obtain from their careers. I would like to invite you to assist me in the investigation of these professional issues.

You have been selected as part of a random national sample of practicing psychologists. If you would like to participate in this study, you will be asked to sign a consent form, and then fill out two questionnaires. The participants in this study are completely anonymous, and there is no record of any type identifying any participants. To insure that security is being maintained, there is also no coding of any type to identify the response forms. All responses will be completely confidential.

Often, people who participate in studies like to find out about the results. If you are interested in the findings of this study, please contact me, and I will be happy to brief you on the outcome of the study, or send you a copy of the results.

Thank you very much for your time and your participation. If you have any questions that you would like to have answered, please do not hesitate to call me: I can be reached at (516) 921-4818.

Sincerely,

Brooke Stevens, M.S.

APPENDIX E

APPENDIX E

ACCOUNTED FOR VARIANCE IN MSQ GENERAL SATISFACTION

AFTER CONTROLLING FOR DEMOGRAPHIC VARIABLES

* * M U L T I P L E R E G R E S S I O N * *

Equation Number 1 Dependent Variable.. TOTLSAT1

Block Number 1. Method: Enter
GENDER FAMINCOM PCTCASE3 WORKTIM2 PCTWRK3 WORKSET

Variable(s) Entered on Step Number
1.. WORKSET Primary Work Setting
2.. GENDER Gender
3.. PCTWRK3 Percent Work Time: UR/Documentationn
4.. FAMINCOM Total Family Income
5.. PCTCASE3 Percent Caseload: White Collar
6.. WORKTIM2 Average Work Time: Non-billable hours

Multiple R	.60473	R Square Change	.36570
R Square	.36570	F Change	2.97884
Adjusted R Square	.24294	Signif F Change	.0205
Standard Error	8.71779		

Analysis of Variance

	DF	Sum of Squares	Mean Square
Regression	6	1358.34669	226.39112
Residual	31	2355.99541	75.99985

F = 2.97884 Signif F = .0205

---------- Variables in the Equation ----------

Variable	B	SE B	Beta	T	Sig T
GENDER	-2.631	3.226	-.128	-.816	.421
FAMINCOM	1.684	.861	.310	1.956	.059
PCTCASE3	.063	.067	.165	.938	.355
WORKTIM2	-.017	.136	-.022	-.127	.899
PCTWRK3	-.313	.174	-.298	-.794	.082
WORKSET	-.582	.899	-.115	.648	.521
(Constant)	76.064	7.351	10.347	.000	

* * M U L T I P L E R E G R E S S I O N * *

Equation Number 1 Dependent Variable.. TOTLSAT1

---------- Variables not in the Equation ----------

Variable	Beta In	Partial	Min Toler	T	Sig T
ETHICS6	-.390	-.445	.635	-2.725	.010
ETHICS10	-.282	-.317	.608	-1.835	.076
TPTXREL	-.435	-.479	.639	-2.993	.005
MC1	-.316	-.325	.587	-1.886	.068
MCURPLIC	-.249	-.285	.614	-1.629	.113
TPINFLTX	-.468	-.505	.601	-3.205	.003

End Block Number 1 All requested variables entered.

* *

Block Number 2. Method: Enter
ETHICS6 ETHICS10 TPTXREL MC1 MCURPLIC TPINFLTX

Variable(s) Entered on Step Number

7..	MCURPLIC	MC UR Personnel non-licensed
8..	ETHICS6	Ethics: Tx Report as Individual React
9..	TPTXREL	TP Impact on Tx Relationship
10..	ETHICS10	Ethics: TP Influence Tx Approach React
11..	TPINFLTX	TP Influence on Tx Decisions
12..	MC1	Ease in Contacting Managers

Multiple R	.78832	R Square Change	.25575
R Square	.62145	F Change	2.81501
Adjusted R Square	.43975	Signif F Change	.0312
Standard Error	7.49949		

Analysis of Variance

	DF	Sum of Squares	Mean Square
Regression	12	2308.28393	192.35699
Residual	25	1406.05818	56.24233

F = 3.42015 Signif F = .0046

Equation Number 1 Dependent Variable.. TOTLSAT1

---------- Variables in the Equation ----------

Variable	B	SE B	Beta	T	Sig T
GENDER	2.354	3.107	.114	.758	.455
FAMINCOM	1.241	.836	.228	1.485	.150
PCTCASE3	.095	.067	.249	1.404	.172
WORKTIM2	-.006	.125	-.008	-.050	.960
PCTWRK3	-.242	.163	-.230	-1.482	.150
WORKSET	.069	.850	.013	.082	.935
ETHICS6	-1.376	1.701	-.148	-.809	.426
ETHICS10	-.232	1.529	-.026	-.152	.880
TPTXREL	-3.065	1.644	-.306	-1.865	.074
MC1	-1.452	1.570	-.182	-.925	.363
MCURPLIC	.390	1.934	.037	.202	.841
TPINFLTX	-2.025	1.950	-.197	-1.038	.309
(Constant)	89.711	9.180		9.772	.0000

End Block Number 2 All requested variables entered.

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