Psychodynamics and Managed Care:
The Art of the Impossible?

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Many mental health providers believe that psychodynamic psychotherapy under managed care is virtually impossible. Notwithstanding the many adversities posed by managed care, there are ways to productively apply psychodynamic principles within this health care financing system. This paper critically discusses the possibilities and costs of conducting psychodynamic psychotherapy under managed care using theory, practice applications, and a case vignette. Central to the discussion is elaboration of five central differences between traditional psychodynamic treatment versus that conducted under managed care.

IMPACT OF MANAGED CARE

Speaking of psychoanalysis and managed care concurrently is tantamount to ideological and economic implosion to many psychotherapists, who view them as completely incompatible and deserving of no common attention. Managed care is an inflammatory term. It evokes images of malignant intrusions into patient treatments, disappearing referrals, and unbearable documentation requirements. And this is for good reason. Managed care has had, in balance, an enormously deleterious impact on the mental health field. On a theoretical level, it challenges both the fundamental belief in unconscious motivation/conflict as well as the conviction that long-term psychodynamic treatment can be maximally productive and efficacious. In this sense, managed care poses a distinct threat to psychodynamic psychotherapy. Thus, it may seem counterintuitive to simultaneously recognize that managed care is not evil, but rather a financially driven management technique that can be negotiated with on an individual level while responded to and challenged on legislative and regulatory levels through education and advocacy. We have a strong identification with the powerful distrust that exists toward managed care,

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yet we also think it not always the most prudent attitude for psychodynamic psychotherapists practicing in today's health care environment.

Managed care has had a strikingly transformative impact on the practice of psychotherapy and on health care financing and accessibility in general. This transformation has included numerous challenges, including:

1. Reduced overall treatment length for outpatient psychotherapies, with little opportunity for long-term treatment when the care is managed;
2. much reduced overall lengths of stay for inpatient treatment, with little opportunity for psychotherapeutic intervention;
3. reduced reimbursement levels and increased nonreimbursed documentation requirements for psychotherapy;
4. an "anti-intellectualization" of psychotherapy process, wherein manualized and proscriptive treatments are being anointed as the singular gold standard to the exclusion of many other curative aspects of the clinical process that are less quantifiable and "tangible;"
5. intrusion of an active third party (i.e., managed care organization) into the therapist-patient dyad.

In addition to these many disadvantages, there have been some opportunities in managed care for certain psychodynamic psychotherapists under certain conditions. We regard the following as potential opportunities:

6. Potentially steady referral base when contracted as a preferred provider on managed care panels;
7. increased incentive to generate a systematic treatment plan and regularly examine its effectiveness;
8. increased discussion with patients about the progress of and their reaction to a treatment.

We have an enduring respect for psychodynamic theory and technique, and eagerly wish that those who share our devotion to this way of understanding and helping people will meet the managed care challenge head on. When Freud, in the face of criticism, took psychoanalysis out of the university setting and established free-standing institutes, it was a questionable move. Many have argued that the isolationism this provoked has been unfortunate, and that it has enhanced the intellectual rifts and distrust between psychodynamic and other forms of psychotherapeutic practice. We see a similar dilemma, in the economic realm, facing psychodynamics today, as reflected in the fact that some advocate for the complete abandonment of any claim to third-party reimbursement or negotiation with managed care. This might result in a marginalization of

psychodynamics from the rest of the mental health field, exacerbating the fragility of those bridges that do already exist. We think such an approach would ultimately be hurtful.

Managed care, just like psychodynamics, is an evolving institution that needs shaping. In our view, the business consequences of managed care are to be negotiated with, but the challenges to the therapeutic relationship, whether in the context of short or long-term psychotherapy, should be confronted.

TO ASSIMILATE OR NOT TO ASSIMILATE?

There are many recent books detailing how a therapist might, if he or she so chooses, work productively with managed care (1, 2). Yet, in addition to our recent monograph (3), there is only one edited book that deals specifically with psychodynamics and managed care (4). In the discussion that follows, we want to address some of the greatest challenges for psychodynamic clinicians posed by working with managed care, and some of the reasons why psychotherapists choose to work with, or choose not to work with, managed care.

A bottom-line stance for many clinicians, and one we have much sympathy with, involves the notion that it is, at best, clinically inadvisable, and, at worst, flatly unethical, to have anything to do with managed care. This view that psychodynamics and managed care are intellectually and ethically incompatible bedfellows has been articulated cogently by Barron (5), who speaks of having

> the uncanny sensation that in the managed care/mental health paradigm, we are undiscovering the unconscious, or at least minimizing its significance in our lives and the lives of our patients. Managed care exemplifies the industrialization of mental health treatment with its ahistorical, narrowly symptom focused point of view and its degradation of the patient-therapist relationship. (p. 2)

Barron's comments underscore the point that we must distinguish the practice of psychotherapy in a managed care environment from the assault that this provokes on our belief in the validity and utility of psychodynamic principles. The growing appeal of manualized and empirically based treatments can be interpreted to mean that nothing effective can occur in a psychotherapy unless it can be isolated, validated, and replicated. It seems vital to recognize that because one cannot devise robust descriptions and tests of all the curative factors in a given treatment, this does not mean that these factors don't exist. Yet, this is the implication in much literature, which seems a simplification of the empirical method. Bornstein's (6)

critique of psychoanalysis on the grounds that its theoretical concepts lack precision and its practitioners fail to "correct demonstrable wrongs" that have no research support is well taken. We would hate, however, to see such a critical discussion devolve into the antiintellectual notion that "if you can't see it and feel it, it doesn't exist." Psychodynamic psychotherapy is much interwoven with the nuances of human interaction, and psychotherapy process and outcome measures are still too much in their formative stages to declare psychodynamic treatment empirically invalid. Yet, if many in both the managed care and the psychotherapy research community are eagerly prepared to do so, it is incumbent upon psychodynamic clinicians to actively reject this stance.

MANAGED CARE VERSUS TRADITIONAL PSYCHODYNAMIC TREATMENT

Contrary to a belief held by many, the same psychodynamic conceptual foundation within which a therapist already operates can similarly be used with many managed care patients. While there is no need to abandon psychodynamics, there are five fundamental differences between conducting psychodynamic treatment within a managed care environment versus conducting a traditional independent psychodynamic psychotherapy (3).

1. In a managed care psychodynamic approach there is little opportunity for an overarching transference analysis paradigm to govern the work, but extratherapeutic transferences can become a treatment focus.

Given the time and outcome constraints, there are obvious cautions on the advisability of an exploratory stance that promotes the unfolding of a transference reaction and the systematic analysis of that reaction. Notwithstanding the arguments for circumscribed and precise transference analysis in short-term dynamic psychotherapies, the majority of psychotherapies under managed care are not conducted within a context that makes transference analysis technically feasible. To engage in such within the structural limitations of time and treatment focus may result in an uncontrolled and unanalyzable transference reaction. (In the specific case of functional impairment coexisting with intrapsychic impairment, however, as we note below, a therapist may have the opportunity to successfully make the case to managed care for an overarching transference analysis paradigm as the most efficacious and cost-effective form of treatment).

We do want to distinguish between a full unfolding of the transference, which is unlikely to be practicable, versus a clinical focus on certain extratherapeutic transferences, which may well be practicable. By extratherapeutic transferences, we mean those transference reactions that nat-

urally occur within the multiplicity of relationships in one's life. We emphasize extratherapeutic because while the concept of transference is not limited to a patient's relations with a therapist, it is most commonly addressed only in this context. To be more specific, any human relationship can be understood to contain derivatives of earlier internalized representations that interact with environmental and temperamental variables to produce the qualities of a current relationship. One can also posit that for some current relationships, these earlier relational representations exert a broader influence than for others. Thus, the relatively small subset of current relationships for which a transference paradigm is basic to understanding the interactive dynamics may be regarded as an extratherapeutic transference.

Extratherapeutic transferences can be used as an alternative focus of the treatment process wherein they become illustrative of core conflictual relationship themes (7). These themes are then used recursively in the service of promoting a patient's understanding, and working through of this understanding, to generate behavioral and affective change. This places the work more so within a psychodynamic supportive than a psychoanalytic insight-oriented modality, but nonetheless a supportive one wherein insight per se can remain a treatment tool in the service of relational change.

2. Choice is made to target one or a very few areas of character and adaptive functioning, rather than addressing many aspects of character and adaptive functioning simultaneously.

In an insight-oriented psychotherapy, a therapist will usually address a patient's character functioning with attention to a broad range of functional and intrapsychic issues. Using the curative vehicle of the transference and other therapeutic/heuristic tools, the treatment goals most often focus on omnibus character functioning and associated symptomatology. Given the constraints of managed care, such an omnibus approach is contraindicated when psychotherapy is conducted under this aegis. What can be done, in contrast, is to orient the treatment around a more circumscribed character variable or small set of variables. In this sense the goals of psychodynamic psychotherapy within managed care parallel the scope of goals that one might have in a brief dynamic therapy, absent the ego-confrontational techniques used in most brief therapies.

This, of course, raises the critical question of whether one can, indeed, intervene with a highly circumscribed aspect of character functioning and really expect to effect significant change. Our experience has been that one can do so, especially with patients who meet many of the screening criteria

of the short-term dynamic therapies, such as psychological mindedness, symptom complaints around a specific area of dissatisfaction, and a reasonable capacity for interpersonal relatedness. Consider, for example, the following case where this was effected:

Vignette

A 66-year-old woman, recently retired from a career as an executive assistant, found herself sleeping poorly, unable to feel comfortable in her home environment, dissatisfied in her relationships with her friends and family, and generally feeling a low sense of efficacy. She had never been in psychotherapy before, and initially became quite anxious in the therapy situation as it activated strong performance anxieties. She had a lifelong pattern, usually beyond her awareness, of trying to make herself interpersonally transparent. This pattern appeared to have clear developmental roots in her childhood experience of an excessively dominant, unpredictable, and aggressive father, and an attentive but passive mother.

Despite all of this patient's discomforts with herself and the therapy situation, she was also interpersonally engaging and wanted to know herself and her motivations better. This motivational hook, and her developmental history, could easily have argued for an intensive psychodynamic psychotherapy that allowed a transference reaction to flourish in the service of reinvoking earlier relational dynamics. Such a treatment would probably best be served by two sessions per week over a number of years. Her managed care insurance plan, however, allowed for merely 30 sessions of psychotherapy per year. Given this constraint, the decision was made to focus the treatment on improving the quality of her close friendships, which was, at that time, the source of her greatest discontent (i.e., helping her to actually experience the closeness rather than just going through the motions).

To effect this outcome, therapy discussions focused on microanalysis and interpretation of interactional sequences for two of the patient's closest friendships. She came to these friendships with the inability to internally track, much less share, certain dimensions of her experience. This was especially true if she felt any form of anger or frustration with her friends, at which point she either thoroughly repressed or consciously disregarded these affects. Through a gradual process of vetting her interactions and chipping away at the repression of negative affects, albeit with considerable anxiety and resistance, functional improvement and increased satisfaction in all her relationships began to emerge. During this process the therapeutic relationship was also used occasionally as a cura-

tive tool in the sense that particular circumscribed feelings that arose in her close friendships would be recognized and discussed as they also arose in the therapy situation. There was emphasis here on the notions of circumscribed feelings and occasional use of the therapeutic relationship in order to allow discussions of these elements to act as an adjunct to the fuller discussions of extratherapeutic transferences, rather than engender a dominant transference enactment. The alliance remained therefore largely positive and the therapy productive, while not embodying the scope and curative depth of a transference-based psychodynamic psychotherapy.

Another interesting characteristic of psychodynamic psychotherapy under managed care is that a treatment may not be an isolated and one-time event, but rather an experience where patients return to you for follow-up at various points over time to address then current areas of conflict. This increased likelihood of engaging with an individual over time is one of the few rather appealing features of psychotherapy under managed care. It also demands that a psychotherapist educate and prepare patients for this scenario, and help them to track their own levels of symptomatology and character distress in order to make judgments about when to seek out treatment once again.

3. Even while still adhering to a psychodynamic conceptual framework, communication of the work to a managed care organization is formulated partly in an alternative functional language that can be more readily understood by those not trained in psychodynamics.

Put simply, treatment reviewers, who are often not trained at the level of a terminal degree in a mental health field, need to clearly understand what a therapist is saying. This is an obvious-enough concept that therapists often violate when communicating the nature of their patient work to a managed care organization. Language that is rich in psychoanalytic conceptualizations will be much less likely to be reviewed favorably than language that is framed in alternative functional language. Such "language" need not be inconsistent with psychodynamics—it should accurately convey a patient's character functioning and symptomatology, but do so using terminology that is readily understandable to anyone with a basic knowledge of mental health treatment issues.

For example, rather than referring to the curative aspects of a positive transference in a supportive psychodynamic psychotherapy of a dysthymic young man with a self-defeating relational history, one might refer instead to the notion of modeling. The parallels between the behavioral technique of modeling and the psychodynamic processes of alliance-building and positive transference are rough, but extant. Yet writing a reauthorization

report for a managed care organization is not rocket science—anything that accurately conveys the spirit of the treatment and the medical necessity, and simultaneously gives as little information as possible in as unobjectionable a way as possible, is the desirable outcome.

Another terminological example is the notion of interpretation, which can be alternatively characterized as reattribution. Interpretation implies an explanatory process wherein a therapist draws meaningful connections between various aspects of a patient's functional and intrapsychic histories. The implicit aim of the interpretive process is always to broaden a patient's understanding, offering new (to the patient) ways of explaining behavior and affective states. In this sense a therapist is helping a patient to alter the locus of meaning that he or she attributes to these behavioral and affective sequences.

4. Given the need for active communication with managed care organizations, the bedrock practice of privileged communication between patient and therapist is not adhered to in the same way as in a traditional psychodynamic psychotherapy. There is the explicit understanding from the beginning of therapy that the patient will be periodically engaged in a treatment review and planning process, and that material justifying authorization will be presented to the managed care treatment reviewers.

One of the primary concerns of psychodynamic clinicians regarding managed care is the issue of the confidentiality (or lack thereof) of clinical information, and the potential impact third-party reimbursement may have on a psychotherapeutic relationship. This is a serious issue, and one that will have an impact on certain treatments more so than others. Managed care organizations would argue that third-party reimbursement is not a mandatory enterprise, and that if an individual is contracting with a company for health care payments, she/he needs to abide by that company's rules for exchange of information. From the clinician's perspective, exchange of information involves, at best, a breach of therapist-patient confidentiality, and, at worst, a threat to the therapeutic alliance and possibly the treatment outcome.

Working with managed care organizations presents the therapist with an ethical dilemma. Psychotherapists are bound by the rules of privileged communication, except in the case of clear and present danger to the patient, threat by the patient toward another, report or clear intent of engaging in abuse toward a minor, or when a specific release of information has been executed. This latter circumstance is a must before any therapist shares information with managed care reviewers. Having the

patient read and sign a release of information regarding sharing of clinical and historical information with the managed care organization "covers" you legally, but the problem remains that confidentiality has been a fundamental practice standard for psychodynamic psychotherapy, and a theoretically congruent one as well. However, as with so many other complex issues in the current health care system, the task is to balance the optimal with the practicable, while all the while maintaining the basic integrity of the treatment situation.

While an enduring therapeutic alliance is undoubtedly a key element of successful psychodynamic psychotherapy, the appropriate sharing of information with a managed care organization does not necessarily destroy this alliance. What seems to be a pivotal factor for therapists who successfully maintain a working alliance is the institution of a treatment frame that, from the beginning, makes clear to the patient the necessity of sharing information, and addresses quite explicitly what type of information will be shared, and under what circumstances.

There is a limited range of treatments for which a breach of confidentiality can pose an insurmountable threat to the alliance, such as in insight-oriented therapy with borderline-spectrum patients, supportive or insight-oriented therapy with paranoid patients, or any insight-oriented treatment where there are overwhelming negative transference paradigms regularly enacted by the patient. In such cases, the most ethical treatment decision may be to forego third-party reimbursement, or accept the higher "out of network provider" nonmanaged care reimbursement, in favor of an unobstructed treatment where no third party is involved. But what about such a patient who could not afford treatment without third-party reimbursement? This too poses a tough ethical question that forces the clinician to balance nonoptimal factors. Except in the rarest of cases, our experience is that external challenges to the alliance, however disturbing to the patient, can eventually be interpreted and worked through. It is likely that many other external interpersonal stressors regularly impinge on the type of patient who is strongly affected by managed care involvement—perhaps it is better to work these conflicts out in treatment than for them to be acted out outside of treatment, and outside of a therapeutic relationship.

5. The need for documentation of therapeutic work to gain authorization requires a significant (unreimbursed) time commitment, which contrasts with the conventional (and increasingly archaic) system of submitting merely a letterhead bill for reimbursement, with no need for authorization.

This final difference we address between conducting a traditional psychodynamic psychotherapy versus one under managed care speaks for itself. A therapist generally has to work 20-30% harder for less reimbursement. Not a happy prospect, and more than enough reason for a therapist to forego working with managed care. But not all therapists have the referral base or patient demographic base that would support a nonmanaged care practice. For these therapists, it is important to know what one is getting into by working with managed care.

The fundamental differences detailed above between conducting psychodynamic treatment within a managed care environment versus conducting a traditional independent psychodynamic psychotherapy are considerable and require much forethought in order to negotiate effectively. Yet while the managed care system will rarely support psychoanalysis per se, or, in most cases, intensive insight-oriented (transference-based) psychoanalytic psychotherapy, there can, contrary to the image of many, be consistent support for supportive psychodynamic psychotherapy.

From a practice perspective, managed care does challenge (but does not always prevent) our ability to treat patients over a relatively long-term period. For example, while some of our own patients with marked psychopathology have been in psychodynamically oriented treatment authorized by leading managed care organizations for more than five years, the majority of cases are not authorized for such a period. To be able to treat a patient for a true long-term dynamic psychotherapy increasingly means forgoing third-party insurance reimbursement. What is important to managed care organizations, and we believe should be to all clinicians, is the ability to make differential decisions concerning the need for and utility of treatment, and to be able to balance these considerations with economic limitations on the overall payout available for mental health services, whether self-pay or third-party reimbursement.

JUSTIFYING TREATMENT UNDER MANAGED CARE

Managed care companies and psychodynamic clinicians must both confront the challenge of balancing economic considerations with treatment necessity. Thus, the goals of clinicians and health insurers are not entirely dissimilar. Rather, it is their relative emphasis that is disparate. Psychodynamic clinicians aim to provide a meaningful human service and make money, while health insurers aim to make money and provide a meaningful service. The significant differential is the relative motivation towards making money versus providing a human service, and the means one engages in to achieve these goals.

Making money is the ultimate goal for managed care and "unnecessary" expenditures make them nervous. What is paramount, then, is to assure the managed care reviewer that the treatment provided is of "medical necessity." This will require the identification and documentation of "treatment need" (i.e., the patient provides a diagnosis and symptom picture that are reasonably treatable), clinical efficacy (i.e., a given treatment has demonstrated results) and cost efficacy (i.e., a given treatment is less costly in comparison to other equivalent treatment).

The bottom line is that we must be savvy in our use of the managed care system and carefully evaluate the necessity of treatment. Of course, there are times when a long-term psychodynamic treatment is both indicated and most appropriate even within a managed care framework. It is the likelihood of reimbursement that becomes dicey. How far one is willing to essentially compromise clinical judgment when intensive psychodynamic treatment is indicated and offer a less-than-optimal option is an individual decision. Most clinicians are in fact faced with this form of compromise regularly as patients try to negotiate between their treatment interests and their available finances. Most people, in fact, who need intensive treatment can't afford it. The significant difference with managed care is that a third party can deny further needed treatment, or even deny initial access to a treatment, rather than treatment decisions being made between a patient and therapist.

In evaluating the likelihood of reimbursement of a given psychodynamic treatment, it may be useful to think of two intersecting dimensions: functional impairment and intrapsychic impairment. Functional impairment refers to the level at which a patient can adaptively engage in regular work, sustain meaningful interpersonal relationships, and live independently, and the extent to which psychological distress and symptom formation impair such functioning. Intrapsychic impairment refers to the level of ego resources, adaptive defenses, appropriate superego controls and sublimatory channels, and the interaction of these factors in producing or diminishing psychological conflict and distress. The interaction of these two dimensions results in four quadrants: functional impairment-intrapsychic impairment; functional impairment-intrapsychic adaptation; functional adaptation-intrapsychic impairment; and functional adaptation-intrapsychic adaptation. This four-quadrant model can be useful in evaluating both the likelihood of managed care reimbursement and the question of which form of psychodynamic treatment to pursue, and is represented graphically in Figure 1. (In discussing which form of treatment to pursue, we suggest largely psychodynamic treatments, yet recognize that

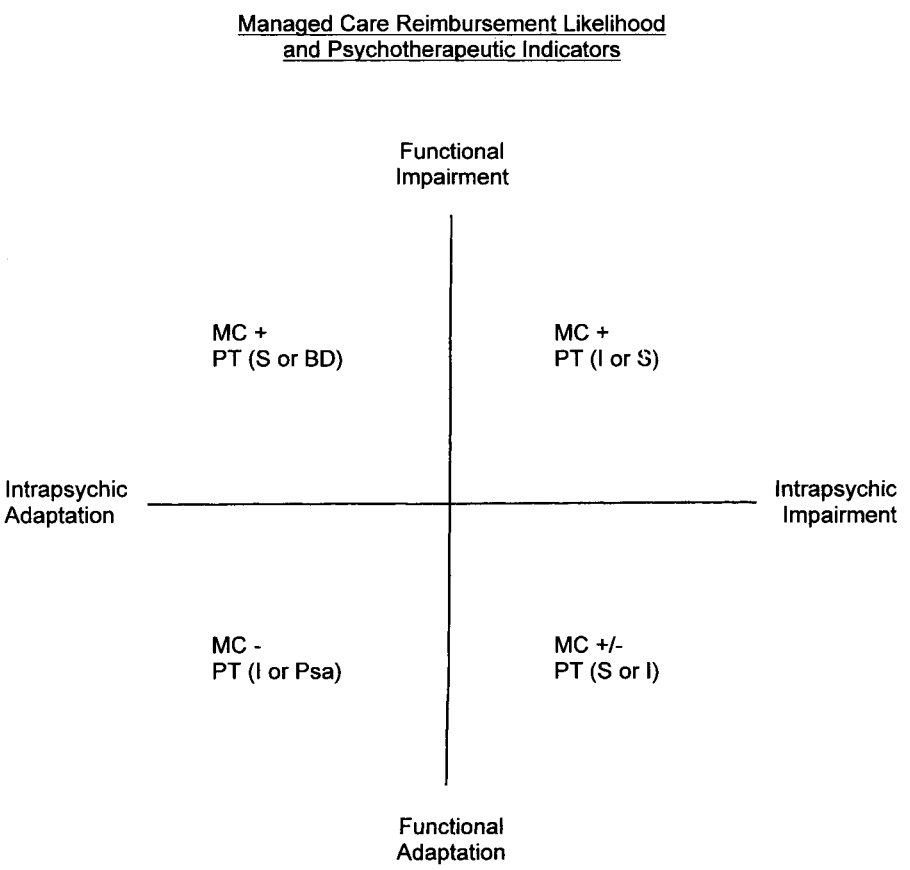

Figure 1

other modalities of treatment are often equally or more indicated.)

FUNCTIONAL IMPAIRMENT/INTRAPSYCHIC IMPAIRMENT

This is the quadrant wherein managed care treatment authorization and reimbursement are most likely to occur, given that impairment exists in a

patient's functioning, which is the overarching benchmark, as well as intrapsychically. The presence of intrapsychic distress presents evidence that the patient might make good use of a supportive or insight-oriented psychodynamic psychotherapy following initial relief of the marked symptoms (which may require medication and/or other forms of intervention). Such a patient would likely be authorized for treatment of a moderate to relatively long-term duration allowing him to benefit from a more intensive transference-based treatment when indicated. Thus, this quadrant presents the strongest possibility to argue with managed care for the optimal type of psychodynamic treatment that might engage transference analysis and a free associative process. The presence of enduring and pervasive functional impairment is key to the likely success of this argument. This quadrant may also represent the type of situation where a therapist feels ethically bound to offer only the optimal treatment a patient needs, regardless of a decision by managed care.

Functional Impairment/Intrapsychic Adaptation

This quadrant represents one in which a managed care organization would be likely to authorize treatment given the level of functional impairment, but where a psychodynamic psychotherapy may be less indicated than a behavioral therapy given the underlying level of intrapsychic (i.e., character) adaptation. When a psychodynamic psychotherapy could be useful, it would likely be either a supportive treatment that addresses behavioral functioning in a pragmatic, albeit psychodynamic, fashion, or a brief dynamic therapy that revolves around a clear problem focus. Treatment for this focal problem is likely to be short-term.

Functional Adaptation/Intrapsychic Impairment

The likelihood of managed care authorization for treatment of a patient within this quadrant is uncertain. Level of functioning is the strongest benchmark when a managed care organization evaluates the need for treatment but if significant intrapsychic conflict, and nonbehaviorally enacted emotional distress, are present, it may be authorized. The functional level may be adaptive, yet internally there is significant conflict and distress precipitated by increasing developmental tasks. Patients in this quadrant could most likely benefit from a brief to moderate duration therapy of a supportive or insight-oriented nature. Whether such treatment would be authorized might hinge on the extent to which, without current intervention, the intrapsychic impairment would be likely to produce functional impairment in the near future requiring a more

intensive level of care, as well as any history of similar conflicts leading to functional impairment.

Functional Adaptation/Intrapsychic Adaptation

This quadrant represents the one least likely to qualify for third-party reimbursement under a managed care system, wherein a patient is functionally and intrapsychically operating at adaptive levels, yet seeks treatment in order to enhance self-awareness and/or to further improve character functioning and quality of life. In this case an insight-oriented therapy or psychoanalysis might be of much use and clinically indicated, but not of any functional or intrapsychic medical necessity, which is the managed care litmus test.

FOLLOWING FREUD'S LEAD

One of the reasons we suggest that psychodynamic psychotherapists consider limited and thoughtful (not wholesale) negotiation with managed care is our belief that psychoanalysis is a dynamic, not static field, that has a tradition of critical thinking and assimilation of new ideas and treatment needs, while also adhering to a well iterated theoretical foundation. Contrary to what some view as the rigidity of classical psychoanalytic theory and practice, many of Freud's cases were, in fact, quite brief. He recognized that one should make critical decisions about the unique treatment needs of each case rather than assuming that each necessarily requires a lengthy course of analysis. Freud would undoubtedly have disliked much of the application of managed care; yet he might not have disagreed with many of its guiding principles. He did argue that one can (and should) work within a psychodynamic framework with flexibility, with ongoing titration of a particular patient's needs to the range of available treatment methods (some of which are not incompatible with a managed care approach), and within the constraints imposed by forces outside the treatment. Consider, for example, the following passage from Freud's paper "On Psychotherapy": (8)

> From certain of my remarks you will have gathered that there are many characteristics in the analytic method which prevent it from being an ideal form of therapy. . . .Psycho-analytic treatment certainly makes great demands upon the patient as well as upon the physician. From the patient it requires perfect sincerity - a sacrifice in itself; it absorbs time and is therefore also costly; for the physician it is no less time-absorbing, and the technique which he must study and practise is fairly laborious. *I consider it quite justifiable to resort to more convenient methods of treatment as long as there is any prospect*

of achieving anything by their means. That, after all, is the only point at issue [italics added]. (p. 262)

What could be more cogent than this recognition of the primary goal of helping a patient to feel and function better in as expedient a fashion as possible? This goal has recently become unmistakable and unavoidable in the practice of psychodynamic psychotherapy. Nonetheless, we must not allow ourselves to adopt the view that just because many longer-term, intensive psychodynamic techniques are neither expedient nor compatible with managed care, this necessarily renders psychodynamics and its intensive application theoretically invalid. To some this caveat is obvious, to others it bears repeating. It has been our experience that even many dynamically oriented clinicians, in addition to those working from other modalities, have begun to internalize the notion that psychoanalytic theory is in demise. This is counterproductive. Fiscal limitations on reimbursement for psychodynamic practice should never be confused with either the fundamental utility of psychoanalytic theory and technique, or the need to take the theory even further.

Psychoanalytic theory has offered, and continues to offer, some of the most profound insights into mental functioning in the affective, cognitive, and behavioral spheres. This has been the case from the inception of the theory to the present. Recent work by psychoanalytically informed clinical researchers in the areas of mental representations/cognitive schema (e.g., Mardi Horowitz; Lester Luborsky), short-term dynamic therapy (e.g., Lee McCullough), attachment theory (e.g., Arietta Slade), and psychopathology and object relations (e.g., Nancy McWilliams, Drew Westen), all offer exciting evidence of psychoanalytic theory's evolving creativity and applicability. Psychodynamics is a diverse and continually emerging field. We should persist in articulating and applying our knowledge of psychodynamic diagnosis (i.e., the developmental foundations of many forms of psychopathology) and psychodynamic differential therapeutics (i.e., which form of dynamic treatment is best for which individual) to our work in the managed mental health care treatment environment.

This managed care environment is still in its infancy, even though it may feel like an excruciatingly prolonged infancy. No doubt it will continue to evolve. We have come a distance from the early waves of managed care in which the allure of high dollar savings, no matter the cost in quality of health care, was irresistible to health insurers and policy purchasers. But we have moved beyond this point to a position where some are now realizing the fiscal benefits of lessening the multiple (and

expensive) layers of case management. This is a promising development that may presage the return of more indemnitylike (and unmanaged) insurance policies. In precisely which direction the field will evolve remains unclear. What is clear is that there is much room for psychodynamically oriented clinicians to impact this direction. Such a proactive stance can include both adaptation and advocacy. Whichever form, we are determined to promote response, and the time for response is still ripe. Five years ago many were predicting that the private practice of psychotherapy by an individual provider with third-party reimbursement would vanish in favor of practice groups and capitation agreements. This has not proved to be the case. There continues to be much room for individual private practitioners in the managed care domain, and this argues for continued and increased lobbying efforts on the part of psychodynamic interest groups in advocating for increased awareness and inclusion.

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