Ethical Issues in Psychodiagnosis

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Diagnostic is a sensitive topic in professional psychology. Many psychologists feel some ambivalence about the professional requirement to diagnose clients’ disorders before beginning treatment (Welfel, 2010). In the past, diagnoses were often considered meaningless categories or denigrating labels. But in 1980 the *DSM-III* was published, and because its nosology was found to be more clinically useful than previous *DSMs*, diagnosis became the cornerstone of clinical practice (Maxmen, Ward, & Kilgus, 2009). Today, there are practicing psychologists who question the usefulness of psychodiagnosis, but few who do not make diagnoses.

Because the diagnosis of client’s conditions is now standard practice, it is important that it be done as accurately as possible. Clients whose disorders are correctly diagnosed can receive the best available treatment and have a good chance of improving. Clients whose disorders are incorrectly diagnosed face the prospect of inappropriate treatment, wasted time and money, and a poor prognosis. Clinicians who make incorrect diagnoses may waste significant time and effort and face ethical and legal sanctions.

Psychodiagnosis in not a strictly scientific or clinical process. It is a complex task, requiring thorough knowledge of the diagnostic system, good interviewing and information gathering skills, and good clinical judgment. Due to this complexity,
competent clinicians can have legitimate disagreements about the diagnosis of a particular client’s disorder. This paper is not about unintentional misdiagnosis, but rather intentional misdiagnosis and related problems that raise significant ethical issues.

Psychology vs. Psychiatry: Conflicting Paradigms

When each new edition of the *DSM* is published, there is controversy about the changes. Some psychiatrists and psychologists have been particularly critical of the *DSM-5* (e.g., Frances, 2013; Greenberg, 2013). One common objection to the manual is that it continues the trend in psychiatry of medicalizing psychological problems and concerns. This highlights a clash between two basic ways to conceptualize psychological disturbance. Many psychologists, and particularly those who favor existential and humanistic approaches, tend to think of many mental and emotional disturbances as functional in nature, and they do not necessarily see their role as “treating patients” who have “mental disorders.” Instead, they talk with clients in a helping context, utilizing the therapeutic relationship and various common and specific therapeutic factors to assist their clients. They tend to see psychotherapy as a therapeutic conversation in the context of a relationship, rather than a medical procedure.

Psychiatrists, on the other hand, tend to think that practically all mental disorders are organic. That is, they are caused by dysfunction in brain neurons and/or neural networks. The authors of the *DSM-5* look forward to the day when “incontrovertible etiological or pathophysiological mechanisms are identified to fully validate specific disorders” (American Psychiatric Association, 2013, p. 20). If mental disorders are organic, it makes sense that they can and should be treated with medications (assuming they are safe and effective, and are used in addition to psychotherapy in most cases). Psychologists cannot prescribe medications (with a few exceptions) and they tend to emphasize the role of talk therapy and related techniques as sufficient to help most clients who have mental/emotional problems.

The *DSM-5* is published by the American Psychiatric Association, not by psychologists, and it presupposes that a medical model is appropriate for categorizing the various forms of psychopathology. Since almost all psychologists use the *DSM-5* to diagnose their clients, but do not necessarily fully accept the medical model, some degree of dissonance is understandable. Many psychologists would probably prefer to have their
own diagnostic manual separate from the *DSM*, but so far no such proposal for a separate nosology has become widely accepted. Almost by default, psychologists have capitulated to the use of the *DSM-5*, like most social workers, clinical mental health counselors, and other non-psychiatric professionals. The American Psychoanalytic Association published its own *Psychodynamic Diagnostic Manual*, but it is not in common use by psychiatrists or most other clinicians (PDM Task Force, 2006).

The *DSM* nosology has become the standard system for diagnosing mental disorders, and it is unlikely that any other system will replace it any time soon. Strictly speaking, usage of the *DSM* nosology is optional and voluntary. When Robert Spitzer, the chief author of the *DSM-III* was told that some clinicians preferred not to use it, he said “Then *don’t*! It’s a free country. *People* wrote *DSM-III*, not *God*” (Maxmen, Ward, & Kilgus, 2009, p. xv).

Why did psychologists capitulate to the use of the *DSMs* over the past few decades? Although there are probably several reasons, the most important is probably economics. Psychologists wanted to be eligible to receive reimbursement for their services from their clients’ health insurance companies. Insurers and other third-party payers required the use of standard diagnostic codes for identifying clients’ mental disorders. Rather than buck the system, psychologists made a devil’s bargain, as if to say “We will use the *DSM* to diagnose our clients so that you will reimburse us for the psychological services we provide our clients (but we do not necessarily accept the medical model when it is applied to psychological distress.” This compromise has been in place for many years and is likely to continue unless and until the *DSM* nosology itself is discarded.

The rise of managed health care over the past 30 years has also been a major influence on psychologists’ view of psychodiagnosis. Managed care organizations (MCOs) not only require psychologists to provide diagnostic codes for their clients’ disorders, they also often attempt to micro-manage the clinicians’ psychotherapeutic work. MCOs usually limit the number of sessions clients may receive, they may require justifications for clinicians’ decisions, and they may suggest how clients with certain disorders should be treated. While the MCOs see their goal as making psychotherapy
more efficient (and thus more profitable), psychologists often resent the interference. This can sometimes result in psychologists not taking the diagnostic process seriously.

Two Common Types of Deliberate Misdiagnosis

There are two main types of deliberate misdiagnosis relevant to the ethical standards for psychologists. The first type is up-coding, or over-diagnosing, which occurs when clinicians select a more severe diagnosis than the accurate diagnosis. This would be done in situations where the accurate diagnosis is not severe enough to qualify for reimbursement from a third-party payer. This is probably the most common type of deliberate misdiagnosis. It is an attempt to deceive a third party in order to obtain treatment for a client and financial payment for the clinician. The practice of submitting inaccurate diagnoses so that clients can receive treatment has been called “diagnosing for dollars” (Wylie, 1995, p. 22). In these cases, since the clinician will not be paid unless the client’s condition is over-diagnosed, the rationale that it is done for the client’s benefit is not completely convincing.

Another type of up-coding involves making a diagnosis of a mental disorder when no such disorder exists. For example, since treatment for marital and family problems (and other “V-code” conditions) is not usually reimbursed, the clinician might assign a diagnosis of a mental disorder to one or more of the individuals in the couple or family so that the treatment becomes reimbursable. Wylie (1995) described this practice as especially common among marriage and family therapists, although it is inaccurate, unethical, and possibly illegal.

The second type of deliberate misdiagnosis is down-coding, or under-diagnosing, which occurs when the clinician selects a less severe diagnosis than the accurate diagnosis, perhaps to minimize the danger of potentially damaging information being recorded in the client’s medical record. Down-coding may also be done to avoid the potentially stigmatizing effect of a more severe diagnostic label, and to avoid harming the client’s self-esteem. For example, a diagnosis of “adjustment disorder” might be used when a more serious diagnosis is more accurate. Wylie (1995, p. 23) quoted a psychologist who said “I diagnosed almost everybody with ‘adjustment reaction’ because I didn’t want to hurt them.”
According to an article in a popular magazine purporting to reveal the secrets of psychotherapists, therapists use the “adjustment disorder” diagnosis because it makes the client eligible for insurance coverage for therapy but is not a particularly severe diagnosis; it “means you are having trouble adjusting to your life. That can apply to almost anybody” (Reader’s Digest, 2012, p. 12). The idea is that anyone who seeks therapy can obtain it because therapists are routinely willing to falsify the diagnosis by calling the client’s normal distress a mental disorder. Some clients do, of course, have an actual adjustment disorder. But it is considered a mental disorder because people who have it have significant symptoms, significant impairment, and marked distress that is out of proportion to the stressor. These criteria exclude the kind of distress almost everyone has occasionally when adjusting to life stressors. Thus, diagnosing an adjustment disorder when the client’s condition does not actually meet the criteria for an adjustment disorder would be misdiagnosis.

Misdiagnosing clients with an adjustment disorder with the rationale that it is the most benign diagnosis that is eligible for reimbursement is in direct conflict with APA and ACA ethical standards; “professional counselors simply do not misdiagnose on purpose” (Kaplan, 2006, p. 38). Since adjustment disorder is a mental disorder (rather than a V-code condition), its treatment was often reimbursed in the past, although recently some insurers have decided to stop paying for its treatment (possibly in response to widespread public articles and comments about its misuse by clinicians).

The Prevalence of Deliberate Misdiagnosis

It is common knowledge in the mental health field that some psychologists, clinical mental health counselors, and social workers do not always take the DSM nosology seriously, and they sometimes deliberately misdiagnose clients in order to “game” the system and get paid. Psychologist John Grohol (2009, n.p.) stated that psychologists give clients a diagnosis whether they need one or not, because without a diagnosis the psychologist will not get paid; “You would be hard pressed to find a therapist who worked for a practice that took private insurance who did not make a diagnosis just so they could get reimbursed.” In an article containing advice for potential clients, Field (2012) stated that psychotherapists routinely exaggerate the diagnosis to get more sessions approved by the client’s insurance company. In her blog “Confessions of a
Therapist” Dancy (2010) stated that psychotherapists deliberately over-diagnose clients’ conditions if necessary to obtain insurance coverage, and make up diagnoses for individuals in a family in order to get paid for conducting couple or family therapy (which usually does not qualify for reimbursement). It is notable that these practices are apparently so common that these clinicians freely imply their own participation in deliberate misdiagnosis. This is probably because such misdiagnosis is difficult to detect and so often goes unsanctioned. Grohol (2009) commented that intentional misdiagnosis for the purpose of receiving payment for therapy is not a practice easily caught, and called it a byproduct of our managed mental health system and its reimbursement policies.

There is a small amount of research on intentional misdiagnosis reported in the professional literature. A survey of clinical social workers (Kirk & Kutchins, 1988) revealed that 80% of the respondents indicated that third-party requirements often influenced their diagnosis of their clients. Many of the respondents complained that an incorrect diagnosis was often required to obtain reimbursement for treatment. Regarding up-coding, 59% of the clinicians reported using more severe diagnoses than were justified in order to qualify for reimbursement, and 25% said they did this frequently. Since reimbursement is not usually provided for treatment of family problems, 86% of the survey respondents said they were aware of cases where individuals were misdiagnosed with mental disorders, even though the primary problem was in the family. When asked about down-coding, 87% of the respondents indicated that they down-coded clients’ diagnoses frequently or occasionally, and 82% admitting using “Adjustment Disorder” frequently or occasionally when a more severe diagnosis was more accurate.

Researchers have found that psychologists are much more likely to use a DSM diagnosis when payment came through managed care than when clients paid out-of-pocket, even when the clients’ symptoms were identical (Welfel, 2010). Ethically speaking, there should be no difference in the diagnosis of individuals in these two groups. Other studies have found that 44% of clinical counselors admitted to changing a diagnosis to obtain insurance reimbursement; 35% of a sample of psychologists admitted to over-diagnosing for insurance reimbursement, and 40% of a different sample of psychologists admitted to deliberately changing a diagnosis to meet insurance criteria.
Eriksen & Kress, 2004; Welfel, 2010). It should be noted that if 35% to 44% of clinicians admit to over-diagnosing for financial remuneration, the actual percentage may be much higher.

Rationales for Misdiagnosis

Clinicians who deliberately misdiagnose some of their clients may think that it is justified because it is either harmless or in the client’s best interest; “a white lie for a good purpose” (Kirk & Kutchins, 1988, p. 231). Under-diagnosis helps the client avoid a stigmatizing diagnosis, and over-diagnosis makes treatment possible for the client, since some clients will not get treatment unless a third party pays for it. Some clinicians may see the requirement for a diagnosis by insurance companies as either a meaningless bureaucratic requirement or a deliberate effort to restrict providing treatment to people who need it.

If viewed from the perspective of an insurer, limits on reimbursement make sense. Clients and the companies where clients work do not pay enough in premiums to make it possible to reimburse providers for unlimited treatment for all conditions, including relatively minor conditions. The line has to be drawn somewhere, and insurers have basically determined that they will pay for treatment for the more severe “medically necessary” conditions, and not pay for the treatment of less severe conditions. People who want health insurance that pays for treatment of less severe conditions (such as the V-code conditions in the DSM-5), and can afford it, can pay for their psychotherapy out-of-pocket. People who cannot afford to pay out-of-pocket can seek services at agencies that offer free or reduced-fee services. The disparity in the incomes of Americans may be unjust, but it is a problem for which there is no consensus solution.

Clinicians may not like where insurers draw the line, or they may think that insurers have their own ethical problems with how they implement their own policies, but this would not justify deliberate misdiagnosis by clinicians. Kirk and Kutchins (1988) make the point that the rationale for over-diagnosis directly contradicts the rationale for under-diagnosis. If the diagnosis of a mental disorder is stigmatizing, then how does the clinician justify deliberate over-diagnosis, which may harm the client? In the case of over-diagnosis, the clinician seems to be willing to take the risk of a stigmatizing label being applied to the client if it makes payment for the treatment possible. Clinicians who
are troubled by the injustices associated with managed health care should advocate for
reform rather than intentionally misdiagnose their clients.

It is tempting to give psychologists who practice deliberate misdiagnosis the
benefit of the doubt. Surely most of them do it for the benefit of the client, rather than just
to make more money. Clinical work is complex, and disagreements among clinicians
about a client’s diagnosis are common. Every individual is unique, and disorders may not
match the prototypical descriptions of disorders in the *DSM-5* and psychopathology
textbooks. The low reliability of many diagnoses in the *DSM-5* contributes to
dissatisfaction with its usage. Clinicians rely mainly on the verbal reports of clients to
make diagnoses. The very nature of psychological disorders is that they are unverifiable
objectively, since there are no known biological markers for most psychological
disorders. The complexity and inherent subjectivity of psychodiagnosis may make some
clinicians feel that a little exaggeration is not a major issue. All of these factors contribute
to making the process of diagnosing a client’s condition more subjective than objective.
Honest mistakes in diagnosis will occur and are inevitable, and there should not be
sanctions for such mistakes. However, intentional misdiagnosis is clearly unethical
because it is fundamentally dishonest.

**APA Ethical Standards Relevant to Diagnosis**

Several of the ethical principles and standards of the American Psychological
Association (2003) are relevant to the topic of psychodiagnosis. Principle C states that
psychologists promote honesty and truthfulness and do not engage in fraud, subterfuge,
or intentional misrepresentation of fact. Standard 9.03 states that psychologists obtain
informed consent for diagnostic services, including an explanation of the involvement of
third parties and limits of confidentiality. These statements make it clear that intentional
misdiagnosis is unethical.

Deliberate over-diagnosis is clearly unethical, both because it is dishonest and
because it is likely to be done as much for the clinician’s benefit as the client’s. A
psychologist might claim to over-diagnosis purely for the client’s benefit, since otherwise
treatment would not be provided. But since they will not be paid unless the treatment is
provided, there is no avoiding the appearance of self-interest. Since deliberate under-
diagnosis may actually make the client’s treatment ineligible for reimbursement, it might
seem less serious and more humane than over-diagnosis. However, the fact that it is
dishonest means that is contrary to the ethical principles of psychologists. In addition, if
under-diagnosis results in inappropriate treatment there is a risk of suit for malpractice
(Kirk & Kutchins, 1988).

In addition to being unethical, intentional misdiagnosis can also constitute
insurance fraud, which is illegal. Griswold (2008) described health care fraud as
deception or misrepresentation by a provider that could result in an unauthorized payment
or benefit. She listed some examples: giving a diagnosis when none exists to gain
reimbursement; over-diagnosis to gain reimbursement or more sessions; under-
diagnosing so that a serious disorder is not recorded, even though it is being treated; and
changing a diagnosis so a client can get more sessions. Griswold (2008) noted that
resentment about insurance restrictions is not a justification for committing fraud.

Moses (2000) considered the question as to whether or not it is ethical to deceive
managed care companies in order to obtain benefits for clients. His conclusion was clear:
despite the many problems with managed care, “Therapists should not deceive managed
care companies in order to obtain benefits for their clients” (p. 219). Such behavior would
violate ethical standards, and active deception for financial gain constitutes fraud. Smith
(2003) agreed: “A patient might ask for a less damaging diagnosis for fear that employers
or others might find out. Or psychologists may consider exaggerating diagnoses to justify
more visits to insurers. No matter what, don’t do it. Honesty is the best policy” (p. 14).
Braun and Cox (2005) made several good recommendations related to the intentional
misdiagnosis of mental disorders: advocate for insurance reform so that all DSM
diagnoses are accepted for insurance reimbursement; discuss the provisions of the client’s
insurance policy with the client; maintain professional liability insurance; learn to
provide quality care without compromising ethical and legal concerns; and “Do not
falsify or misrepresent any information or facts regarding insurance claims and cost
reimbursement” (p. 43).

Refraining From Making a Diagnosis

Although making an accurate diagnosis is the standard prerequisite to beginning
psychotherapy, there is an exception to this standard practice. According to the APA
Ethical Principles (2003, p. 3) the goal of treatment is “the welfare and protection of the
individual” and “to benefit clients” and “to do no harm.” This suggests that in some cases psychologists may be ethically required to refrain from making a diagnosis. The Code of Ethics of the American Counseling Association (2014) specifically states that counselors may refrain from making and/or reporting a diagnosis if they believe that it would cause harm to the client or others. It is unknown how often psychologists and counselors refrain from making a diagnosis based on this ethical principle. There are, of course, consequences that follow refraining from diagnosing a client’s mental disorder. For example, although the client may avoid the potential stigma of having a diagnosis in their medical record, the client’s treatment might not be reimbursable by a third-party payer. If coverage is not available, other options should be discussed, such as out-of-pocket payment or the provision of therapy for a reduced fee. Clinicians can also refer clients to other providers or community agencies that offer psychotherapy on a sliding scale of payment.

Having An Adequate Basis for Diagnosis

Another ethical issue regarding diagnosis relates to the necessity to have an adequate foundation for making a diagnosis. Allen Frances, who chaired the *DSM-IV* Task Force, wrote that “Accurate diagnosis can bring great benefits; inaccurate diagnosis can bring disaster” (Frances, 2013, p. 15). He offered several guidelines for making accurate diagnoses, including the following. Be sure to allow adequate time for each interview, and realize that it may be necessary to have multiple interviews over time to determine the diagnosis. Except in the clearest cases, conduct several interviews before making a diagnosis. No one source of information is complete, so in addition to talking to the client, collect information from other sources. Never blindly accept a prior diagnosis by someone else; always conduct your own evaluation. Revisit your diagnosis frequently and correct it or fine-tune it as needed. Be sure to keep good records to document the basis for your diagnosis.

Informed Consent and Diagnosis

Clients should be informed of the diagnosis being considered for their condition, and given the opportunity to discuss it with the clinician. The APA ethical standard 3.10 requires that psychologists obtain the client’s informed consent for assessment, therapy, and related services. The APA ethical standard 4.02 requires that psychologists discuss
with clients the limits of confidentiality and the foreseeable uses of the information generated through their psychological activities.

Similarly, the ACA ethical standard A.2.b. states that “Counselors take steps to ensure that clients understand the implications of diagnosis” (p. 4). ACA standard E.5.a. states that “Counselors take special care to provide proper diagnosis of mental disorders” (p. 4). Psychologists and counselors should discuss the regulations and limitations of the client’s insurance service provisions at the beginning of the relationship (Braun & Cox, 2005). Potential consequences of coverage being denied should also be considered, along with other options for treatment.

Conclusion

This article has described several ethical issues related to psychodiagnosis, including intentional misdiagnosis, over-diagnosing, under-diagnosing, refraining from making a diagnosis, and other issues. Much more information on these and other ethical issues relevant to psychodiagnosis is available in the literature (Nagy, 2005; Maxmen, Ward, & Kilgus, 2009; Remley & Herlihy, 2005; Welfel, 2010). These authors address additional ethical issues relevant to diagnosis, including confidentiality, documentation, cultural diversity, and working with managed care organizations. While the diagnosis of mental disorders is a complex and challenging task, the ethical standards of professional organizations provide clear guidance regarding how to conduct diagnosis in an ethical manner.
References


