Too Few Symptoms to Diagnose? A Managed Care Ethical Dilemma

by

Amy Michael Racanello

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Georgiana Shick Tryon, Ph.D.

_____	_____
Date	Chair of Examining Committee

Mario Kelly, Ed.D_____

_____	_____
Date	Executive Officer

Dr. Jay Verkuilen_____

Dr. Helen Johnson_____

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

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Abstract

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Advisor: Georgiana Shick Tryon, Ph.D.

Managed care rations health care to populations by using *gate keeping* methods to counterbalance cost. Subsequently, managed care dictates treatment decisions made by practitioners. Managed care has been implicated in damaging relationships within the clinical practice of psychology that unethical and fraudulent practitioner behaviors, and undesirable the client-practitioner relationships. The present study built on the design and results from the pilot study. It was an attempt to explore the relationship between managed care and psychologists' unethical behaviors, and understand the characteristics, specifically empathy and narcissism, of psychologists who behave unethically when assigning diagnosis required by managed care companies. Of particular interest to this research was an examination of individuals who report incongruous personal ethical personal standards and behaviors. The pilot study revealed a sample of the participants who reported that they acted ethically and abided by professional ethical standards all of the time. These same individuals also reported that they would incorrectly diagnose a client who did not meet diagnostic requirements to receive payment for services through managed care. Participants included 101 mental health practitioners. Data were collected with an online survey, that included measures of personal characteristics, professional

ethics, empathy (Spreng et al., 2009), narcissism (Corry et al., 2008), motivated reasoning, and diagnostic decisions. Correlational analyses indicated that personal and professional characteristics are positively related to practitioners reporting that there are reasons to assign unmerited diagnoses to clients. Conjoint analysis, using logistic regression, indicated that practitioners who reported that there are reasons to assign unmerited diagnoses to clients and unwavering adherence to the APA ethics code most frequently assigned unmerited diagnoses to fictional clients. A sub-group of the participants from the current work again reported that they acted ethically and abided by professional ethical standards all of the time but demonstrated unethical behavior. This finding and practitioner individual differences related to diagnostic behavior are both topics for fruitful future research.

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Writing this acknowledgement section has been by far the most difficult task of the entire dissertation process. Articulating my appreciation to those to have made my work possible is impossible. With that said, the following words of thanks are entirely unable to do the depth of my gratitude justice.

Although seemingly odd, my first set of thanks is extended to all those who have presented me with life challenges, both great and small. Thank you for forcing me to believe in myself and appreciate the strength and determination of my own grit and moxie.

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Albert Schweitzer said, "At times our own light goes out and is rekindled by a spark from another person. Each of us has cause to think with deep gratitude of those who have lighted the flame within us." My third set of thanks is extended to all those who have been a spark to me…I am eternally humbled, privileged, inspired, and indebted to you all.

And finally, "Too Few Symptoms to Diagnose? A Managed Care Ethical Dilemma" is dedicated with a loving heart to George and Georgiana…

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Chapter I

Introduction

Managed care is the term used to describe the management of prepaid health care distribution systems that regulate and monitor input and output of medical and mental health services. The majority of the American population utilizes managed care insurance, thus mental health care-providers reorganized and adapted their practice and treatment methods to work under the imposed guidelines. Managed care rations health care to populations, and uses regulations to counterbalance cost of services. Managed care policies with regard to mental health services include companies control of: (a) types of services rendered, (b) duration and frequency of sessions granted, (c) length of inpatient stays, (d) patient risk sharing, (e) employing of less qualified providers, and (g) provider risk-sharing (Sanchez & Turner, 2003).

The literature points to a positive association between managed care use and unethical behaviors by mental health professionals acting unethically to attempt to ensure that they will receive reimbursement for services rendered (Kielbasa et al., 2004; Lowe et al., 2007; Pomerantz & Segrist, 2006; Racanello, 2010). Although all members of the American Psychological Association (APA) must accept the ethics code and are assumed to understand that ethical violations can lead to various levels of reprimand, psychologists who work within managed care systems seem to disregard professional ethical standards, including: informed consent, confidentiality, record maintenance, competence, integrity, avoidance of harm, and conflict of interest (Daniels, 2001).

The pilot study for this dissertation specifically queried participants about why they chose to give a diagnosis to clients' who did not require one. Participants responded

that they had to give a diagnosis to be reimbursed for treatment rendered (Racanello, 2010). This lead to the question: How can psychologists who say they behave ethically reconcile the unethical behavior of assigning diagnoses to clients for which their symptoms do not meet criteria? A disparity appears to exist between psychologists' self-beliefs that they are ethical and their demonstrations of unethical behaviors.

A disconnect between perception and action leads to cognitive dissonance (Festinger, 1957). Cognitive dissonance occurs when thought A is not subsequent to thought B; instead thought A is followed by the opposite of thought B. When dissonance occurs in individuals, they feel psychological discomfort, and are motivated to reduce the dissonance. To reduce dissonance between beliefs and behaviors, individuals adopt attitudes that are complimentary to the endorsement of negating constructs. The theory of motivated reasoning purports that individuals come to conclusions that they want to reach because they are personally *motivated* to do so. Humans process information by cognitive schemas, including self-schemas. Using self-schemas individuals *selectively* filter information and gather evidence to support their hoped for conclusions (Aronson & Reilly, 2006).

According to the pilot study results (Racanello, 2010) it seems that participants used self-schemas to report that they believed they are always ethical but simultaneously acted unethically. One survey item specifically asked participants why they would diagnose a client incorrectly. A substantial number of participants indicated that they would assign a faulty diagnosis to be reimbursed for services by managed care; however these same individuals reported that they are ethical without fail. It is possible that individuals used a selective memory search when responding that they act ethically all of

the time. Perhaps these participants thought of times when they were ethical when answering the item. To examine possible selective perception further the current study, asked participants to comment on two scenarios that described unethical behavior. One scenario described *general unethical* behavior and the other described *unethical behavior associated with managed care*.

Unethical clinical decisions are strongly related to self-interest and negative outcomes (Tenbrunsel & Messick, 2004), such as legal trouble. Intentional misdiagnosis is considered fraudulent behavior (APA, 2002). Previous studies indirectly suggest that some psychologists report that acting fraudulently with regard to managed care is *worth it* to fulfill personal self-interest. Thus, the current study attempted to understand the personality characteristics associated with individuals who consider unethical professional behavior worth it, as well as, to understand individuals who self-report high morals but demonstrate admitted unethical behavior. Unethical decisions are correlated with specific personality characteristics associated with low emotional intelligence (Meser-Magnus, Viswesvaran, Deshpande, & Joseph, 2010): high narcissism and low empathy (Brown, Sautter, Littvay, Sautter, & Bearnes, 2010; Monro, Bore, & Powis, 2005). The current study attempted to assess participants' characteristics of empathy and narcissism specifically.

Participants were asked to complete surveys that included items about demographic information, diagnostic decisions, professional ethics, empathy, and narcissism. Individuals were presented with four client vignettes, and two reasoning scenarios; after each, they answered related questions. Based on previous research

(Kielbasa et al., 2004; Lowe et al., 2007: Pomerantz & Segrist, 2006; Racanello, 2010) the current research was designed with the following hypotheses:

- A substantial number of the clinicians will assign a DSM-IV diagnosis to the clients even though the clients present with sub-threshold symptoms.
- A substantial number of participants will assign the diagnosis, and report that this diagnosis was assigned to enable reimbursement by third party providers.
- Within the group of practitioners who assign unmerited DSM-IV diagnoses, a substantial number of practitioners will concurrently report that they are ethical 100% of the time.
- Practitioners who assign unmerited DSM-IV diagnoses will have higher levels of narcissism and lower levels of empathy than practitioners who do not assign unmerited DSM-IV diagnoses.
- Significantly more practitioners who assign unmerited DSM-IV diagnoses that practitioners who do not will state that the individual in the reasoning scenario who acts unethically in a managed care situation acted ethically.

Chapter II

Literature Review

This chapter reviews the literature concerning differences between psychologists' diagnostic decisions related to clients who self-pay for services compared to clients whose services are paid for by health insurance. The chapter discusses managed care's relationship to (a) the Ethical Standards of the American Psychological Association (APA, 2002), (b) psychologists' practice, (c) cognitive dissonance and distortions, (d) motivated reasoning, and (e) personality characteristics associated with unethical behavior.

Managed Care and Psychology Health Service Providers

Managed care is the term used to describe the management of prepaid health care distribution systems that monitor input and output of services. Managed care rations health care to populations, and uses *gate keeping* methods to counterbalance cost including: utilization review, practice profiling, session limits, reduced inpatient stays, patient risk sharing, under qualified providers, and provider risk-sharing (Sanchez & Turner, 2003). Additionally, managed care policies dictate many treatment decisions including: granting access to clients to see mental health care providers, specifying and approving types of services rendered, and determining duration of treatment. In response to the utilization of managed care insurance by the majority of the American population, mental health care-providers reorganized and adapted their practice and treatment methods to work under the imposed guidelines (Sanchez & Turner, 2003).

Managed care requirements. Managed care companies require a *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [DSM-IV-TR]; American Psychiatric

Association, 2000) diagnosis to verify that a client needs treatment and to justify the compensation paid to the mental health professional for working with the client. Additionally, managed care companies often require brief therapy techniques and limit the number of treatment sessions that their consumers may use during a billing period, even when this is not considered *best practice* (Browns & Jones, 2005). Brown and Jones (2005) examined the relationship of treatment outcomes to the duration of treatment. They found that patients who have high levels of distress have the best chance of improvement when they remain in treatment for a sufficient number of sessions (Brown & Jones, 2005). This research suggests that the session number restrictions imposed by managed care keep many clients from receiving sufficient treatment.

Managed care regulations also limit psychologists' use of assessment measures. Psychologists use evaluations less frequently than they did previously because of managed care constraints. Decreased testing is correlated with the high cost of assessment tools and limited reimbursement for testing by managed care providers. Specifically, managed care companies consider psychological evaluations time-consuming, costly, and not beneficial to health care providers' treatment decisions (Turchik, Karpenko, Hammers, & McNamara, 2007). Turchik et al. (2007) imply that due to manage care rules when clients require thorough testing to differentiate diagnoses and plan efficacious interventions, psychologist either do not do the assessments and/or administer abbreviated batteries.

Negative effects of clinical practice correlated with managed care requirements. The pilot study for this dissertation examined the effects that occurred because managed care companies require mental health professionals to assign a DSM-

IV diagnosis to validate a client's need for treatment (Racanello, 2010). The literature explains that this diagnostic restriction is associated with mental health professionals' provision of psychiatric diagnoses for clients whose symptoms do not merit them (Kielbasa, Pomerantz, Krohn, & Sullivan, 2004). Unless practitioners provide diagnoses, managed care companies will not pay for treatment. Practitioners most frequently assign a diagnosis of adjustment disorder because it may (a) be considered less severe, stigmatizing, and/or damaging than other DSM-IV diagnoses, (b) be a fairly accurate representation of the client's symptoms, and (c) include the widest range of symptoms and possibilities compared to other DSM-IV diagnoses, which have more specific diagnostic criteria (Kielbasa et al., 2004).

Providing diagnoses for clients, whether justified or not, grants psychologists access to patients and allows them to provide needed care. When unjustified, diagnoses can lead to several complex deleterious issues for both clients and professionals. First, clients who receive unwarranted diagnoses may view themselves as mentally ill, which could worsen their presenting issues. Second, diagnosed clients have a psychiatric diagnosis on their managed care health records, and confidentiality of these diagnoses is beyond the control of both the client and the mental health professional. Third, psychologists may have to alter the course of treatment to compliment the clients' *diagnoses* (Kielbasa et al., 2004). Fourth, when professionals diagnose clients who do not meet diagnostic criteria, they act in an unethical and illegal manner. The American Psychological Association's (APA) ethical standards specifically require integrity; reporting inaccurate information to managed care providers is considered fraudulent (APA, 2002). Fifth, the client-psychologist relationship is altered when clients are

deliberately misdiagnosed. When health providers inform prospective clients about the impact that managed care will have on the psychologists' diagnoses and treatment the clients' feelings towards the services changed substantially (Cohen et al., 2006). Interestingly even though the information adversely changes clients' perspectives about the efficacy of treatment and ethics of providers, clients believe they have a right to know this information (Pomerantz, 2000, as cited in Kielbasa et al., 2004). Throughout all five issues, reported unethical behavior on the part of the clinician, related to managed care, as per the APA Ethical Standards is a common and prevalent characteristic.

Managed care and school psychology. Although given almost no attention in the literature, managed care has impacted the work of school psychologists. Crespi and Hughes (2003) suggested that school psychologists and school-based mental health interventions play a key role in primary prevention and interventions provided to students. Specifically researchers purported that further utilization of school based mental health services would be beneficial and needed, due to increased numbers of school children and adolescents in crisis and high cost of mental health services (Crespi & Hughes, 2003).

An increased number of public school districts seek reimbursement for services provided students. As of 2004, 75% of mental health services provided to children were given in school settings (Crespi, 2004). The relationship between managed care and school psychology, as well as the influences managed care has had on school psychology, are unknown. School districts seem compelled to receive third party reimbursement for services rendered, and currently managed care restrictions cannot suspend and/or terminate services provided to students. However, if managed care companies alter

treatment requirements for services provided to children in school settings, the impact will be immense. Specifically, such changes will likely affect confidentiality, training, and credentialing of service providers: diagnostic and treatment decisions: home-school relationships: and the goals of treatment (Crespi, 2004).

Ethical Dilemmas in Ethical Standards

Ethics originated from the Greek word *ethos*, which means character or custom, and phrase *ta ethika*. *Ta ethika* was the phrase used by Plato and Aristotle to describe their study of Greek values and ideals. Thus the modern term "ethics" encompasses a system of behavioral principles that guide both individuals' characters, as well as, the larger character of the overall society (Jacob & Hartshorne, 2007).

Professional codes of ethics, including the APA Ethical Standards, seem to have developed at least partially out of psychology's self-interest. Ethical standards signify a professional group's dedication to defining appropriate conduct and maintaining self-regulation of its profession and professionals (Jacob & Hartshorne, 2007). Thus, ethics codes have become a hallmark of professional maturity by promoting the professions' reputation and reducing the apparent need for external regulation. Ideally, the goal of ethics codes is to echo the moral standards that underlie the profession, such as behaviors that are aligned with doing good, not harming, respecting others, and treating all individuals justly and fairly (Fisher, 2003). Logistically, professional ethics codes also include specific regulations to be followed when problems arise in the profession (Jacob & Hartshorne, 2007). The Ethical Principles of Psychologists Code of Conduct appears to have been formulated in this fashion.

The General Principles of the APA Ethical Standards express the moral aspiration of psychology's general community objective. The overall purposes of the APA ethics code can be captured by four goals: (a) institute the integrity of the overall profession, (b) create socialization between educational and professional facets, (c) establish public trust, and (d) implement values (Fisher, 2003). Specifically, the General Principles are meant to inspire psychologists to conduct themselves as per the highest ethical ideals of the profession; the five General Principles are: (a) Beneficence and Nonmaleficence, (b) Fidelity and Responsibility, (c) Integrity, (d) Justice, and (e) Respect for People's Rights and Dignity (APA, 2002). At the same time, the Enforceable Standards of the APA Ethical Standards are rules of conduct including guidelines for practitioners' conduct and their interactions with other individuals (Jacob & Hartshorne, 2007).

Discrepancy exists between ethics codes and ethical conduct because ethical conduct is more complex than individuals following a set of regulations, and professional ethics codes are imperfect for three main reasons. First, ethical codes can be ambiguous since codes are written in terms of general principles, using language such as "reasonably clear that a client/patient no longer needs service." Second, ethics codes often include competing ethical tenet and also conflict with federal and state laws, such as practitioner maintenance of client confidentiality and concurrent reporting to third-party providers. Third, ethical codes are often formulated in a reactive manner, thus the code is revised only after ethical issues have occurred (Jacob & Hartshorne, 2007). With regard to manage care, the Enforceable Standards of the APA Ethical Standards are imperfect and most notably includes standards that are in conflict with other standards.

Thus, the question that arises is: are ethics codes ethical or are they simply codes of professional conduct with incorrect labels? This specific topic is further explored in the discussion section of this dissertation. Let it be noted that throughout this document the term ethical is used as per the APA definition.

Ethical Standards Related to Managed Care

All members of APA accept the ethics code and are assumed to understand that violations of it can lead to various levels of reprimand, including expulsion (LaRoche & Turner, 2002). When psychologists work within managed care systems they must consider several ethical issues that inevitably arise including those that involve: informed consent, confidentiality, record maintenance, competence, integrity, avoiding harm, and conflict of interest (Daniels, 2001).

Informed consent. Informed consent is the strategy used to protect the autonomy and privacy of the people with whom psychologists work (Fisher, 2003). Thus, psychologists need to clearly explain fees, billing arrangements, and limits of confidentiality that occur when working under managed care plans (Daniels, 2001). According to the Standards on Therapy, specifically Standard 10.01, psychologists must obtain informed consent as early as possible. Practitioners must explain the following topics to clients: nature of therapy, anticipated course of treatment, fees, involvement of third parties, and confidentially (APA, 2002). Informed consent may need to be, and often is, an ongoing discussion between the psychologist and the client. For example, psychologists may need to wait for responses/approvals from managed care companies before completing the informed consent discussion. Additionally, psychologists are required to inform clients if managed care companies are entitled to receive diagnostic

information based on the contracts between the managed care companies and the psychologists, and the contracts between the managed care companies and the clients (Fisher, 2003).

Confidentiality. Confidentiality traditionally refers to the assurance that psychologists keep patients' information classified. However, with the advent and popularity of managed care, many people now have access to client information. To certify initial treatment and to authorize continued treatment, managed care companies often require client information from psychologists (Daniels, 2001). According to Standard 10.01, clients who pay via managed care plans must be informed of the extent to which practitioners will disclose diagnosis, treatment plans, and other personal information to individuals working for managed care companies (APA, 2002, p.1072).

Record maintenance. Record maintenance is outlined in APA Standard 6.01. It explains that psychologists must create, maintain, disseminate, store, retain, and dispose of records and data in a fashion that enables psychologists to use the materials effectively (APA, 2002, p. 1067). It is imperative to note that managed health care companies are not permitted to require psychologists to release psychotherapy notes for the provision of treatment, payment, enrollment in a health plan, or eligibility benefits (Fisher, 2003).

Competence. Competence refers to the specific services and techniques for which a professional is sufficiently trained and prepared to provide. Often managed care contracts require mental health professionals to employ brief therapy models when working with clients (Daniels, 2001). Thus, psychologists must be properly trained and competent in such models to join and provide certain managed care services. Specifically, Standard 2.01 indicates that psychologists are not allowed to provide "…services…in

areas they have not had… education, training, supervised experience, consultation, study, or professional experience recognized by the discipline as necessary to conduct their work competently" (APA, 2002, p. 1063-1064).

Integrity. Integrity refers to being truthful, just, and respectful (APA, 2002). With regard to managed care this means that psychologists must be accurate when reporting information to managed care companies. Thus, psychologists must be honest even when their abilities to provide adequate services to clients are limited by managed care guidelines. Specifically, psychologists are not permitted to up-code or down-code diagnoses (Daniels, 2001).

Up-coding is when a practitioner assigns a client/patient a more severe diagnosis than she/he warrants. Up-coding is often done to attain approval for initial treatment, and to have a greater number of sessions approved by the managed care company. Down-coding is when a practitioner assigns a client/patient a less severe diagnosis than he/she warrants; this is also used to attain approval for treatment. Often managed care companies refuse to approve payment for Axis II disorders (4th ed. [DSM-IV-TR]; American Psychiatric Association, 2000). Axis II disorders are considered to have a chronic course and are associated with intensely severe problems (American Psychiatric Association, 2000). Thus when clients present with Axis II disorders, psychologists may down-code and only report Axis I diagnoses. These professionals deliberately ignore the Axis II diagnosis (4th ed. [DSM-IV-TR]; American Psychiatric Association, 2000) when reporting to managed care companies to obtain approval for treatment (Daniels, 2001). Daniels reported that over 70% of counseling psychologists admitted to down-coding, and over 60% of counseling psychologists admitted to up-coding diagnoses (Daniels,

2001). According to Standard 6.06, psychologists must report accurate diagnostic information to managed care companies. When psychologists report inaccurate information, whether up-coded and/or down-coded, they are in violation of this standard (APA, 2002. p. 1062).

Termination. When managed care companies refuse to approve additional sessions for clients, psychologists are forced to terminate therapy. According to Standard 10.10, psychologists are permitted to terminate therapy when managed care companies reject recommendations to approve additional sessions (APA, 2002, p.1073). However, according to APA Ethical Standard 3.04, psychologists are required to safeguard the welfare of those with whom they work and avoid or minimize harm. Additionally, Standard 10.10 requires informed consent about the course of treatment (APA, 2002, p. 1073). To avoid harm and be in accord with ethical standards concerning termination and client welfare psychologists need to inform clients at the beginning and throughout the course of treatment that their managed care provider may not approve of additional sessions.

Conflict of interest. Conflict of interest may occur when there is a triangular relationship between a psychologist, managed care provider, and client. Additionally, conflict of interest may occur when managed care companies require brief therapy techniques, but the psychologist believes that this form of treatment is not the most appropriate intervention for the client. According to Standard 3.07, psychologists are required to explain to both managed care companies and to clients of the relationship that the psychologist has with each party. The explanation needs to include a definition of the role of the psychologist, citing who the client is, indicating who will receive information

about the services, and explaining the use of information and services provided (APA, 2002, p. 1065).

Beyond the scope of the explanation of Standard 3.07 and this study, managed care's involvement in psychotherapy has produced a triangular relationship. Relationships between/among managed care companies, clients, and mental health practitioner are multidimensional and multifaceted.

Research Review of Managed Care and Psychologists' Practices

Managed care policies have inflicted many modifications on the practice of psychotherapy. Prior to the work of Cohen, Marecek, and Gillham (2006), researchers examined responses from self-report surveys to gauge psychologists' opinions about the relationship of managed care to their work and professional satisfaction. Managed care is related to: (a) negative experiences for clinical work, (b) inadequate number of sessions for treatment, (c) decreased capacity for clinicians to use their most efficacious clinical judgment, (d) premature termination, (e) restrictions on assessment and evaluations, (f) compromise of patient confidentiality, (g) and unethical behaviors on the part of clinicians (Cohen et al., 2006).

To closely examine the relationship of managed care to changes inside of "therapy" researchers asked, "If therapists, practices, and clients' experiences in therapy sessions are changed by the demands of managed care?" (Cohen et al., 2006, p. 252). In an attempt to gain specific and detailed information from the participants, they used semi-structured interviews with open-ended questions. The analyses examined the clinicians' thoughts about the therapist-client alliance, roles, and expectations (Cohen et al., 2006).

Cohen and colleagues (2006) conducted in-depth semi-structured interviews with mental health professionals: 16 clinical psychologists, 1 psychiatrist, and 1 clinical social worker. The information that they elicited from participants included: (a) standard questions to understand their practice, client population, and history with managed care involvement: (b) open-ended questions about therapy and client relationship while working with managed care companies: and (c) open-ended questions about professionals' personal strategies to enable them to work with managed care companies.

Participants' answers were analyzed using a structure analytic approach developed by Aurbach and Silverstein (2003). Cohen et al. (2006) found a substantial conflict between mental health professionals and managed care companies. Participants reported that managed care companies *demanded* that they engage in several practices that (a) interfered with their personal and professional standard of ethics, (b) undermined their therapeutic work with clients, and (c) damaged the client-therapist relationship.

Cohen et al. (2006) reported that clinicians' approaches to therapy were altered in the following specific ways: (a) clinicians are pressured to focus interventions on superficial issues as opposed to underlying problems: (b) therapists are compelled to employ interventions that are out of their range of competence: (c) managed companies do not approve of treatment for all conditions, regardless of client need: (d) duration of therapy is determined by managed care companies, instead of by the client's need and/or therapist's professional judgment: (e) the therapeutic alliance is weakened: and (f) therapists are required to alter therapeutic interventions and protocols (Cohen et al., 2006). Researchers suggest that compliance with most of these managed care requirements *obliges* clinicians to violate APA Ethical Standards.

Further, the researchers reported that managed care companies *demand* confidential information about clients including the specific assignment of the diagnostic disorder to approve treatment. The participants believed that the information required by managed care companies interfered with the clients' privacy rights and needs. Additionally, participants reported that the information that managed care regulations require inhibits individuals from entering therapy (Cohen et al., 2006).

Cohen et al. (2006) reported that therapists observed discrepancies and misinterpretations by clients who entered therapy via managed care plans compared to clients who paid out-of-pocket. Therapists reported that clients who pay via managed care: (a) misunderstand the gestalt of therapeutic intervention, (b) believe that therapy is a *buyable service*, instead of an interpersonal process that leads to positive change and development, and (c) feel restricted in their choice of clinicians with whom to work (Cohen et al., 2006).

Cohen et al. (2006) reported that mental health care professionals employed *methods to resist and work around managed care terms and conditions*. To ensure approval of reimbursement and to obtain increased numbers of sessions, clinicians stated that they emphasized negative features and symptoms of clients' presentations when reporting to managed care companies. Practitioners described their clients' conditions using financial terms and managed care language. Although they participated in managed care plans, clinicians limited the number of managed care clients they took on, and accepted managed care clients only when they *needed to* (Cohen et al., 2006).

If the participants' experiences are representative of psychologists' work with managed care companies, than the growth of managed care in the medical community has

serious ramifications for psychological services. Psychologists who participant in managed care plans show decreased personal confidence, lack of integrity, and poor public image. Although insightful, Cohen et al.'s (2006) research was qualitative and employed a small sample. Thus, the results should be regarded cautiously.

Cohen et al.'s (2006) work exhibited several limitations, and did not attend to psychologists' unethical professional practices. Importantly, the authors reported the study's findings using deceptive language (Tenbrunsel & Messick, 2004). This means that when participants reported unethical practices, Cohen et al. (2006) *edited* the practices when writing the article to portray the harmful, unethical, and corrupt behaviors as acceptable. Cohen et al. (2006) reported that participants use *buzzwords* when speaking to managed care companies to ensure approval for therapy sessions: "Reframe clients' problems and progress using the language of managed care" (p. 257). When language circumlocution occurs individuals do not clearly see behaviors as questionable because the corruption is disguised by the *padded language* (Tenbrunsel & Messick, 2004). It seems that this happened here.

Although ethics were not the focus of this research (Cohen et al., 2006), the results were reported incompletely and the relationship of managed care to practitioners' unethical and illegal behaviors was disguised. Throughout the semi-structured interview scripts participants reported that they repetitively acted unethically. One participant reported, "There's no diagnosis for a couple's sex problem, so then you have to find some reimbursable diagnosis that works. A long time ago, I decided I would use a very vague diagnosis of Adjustment Disorder" (Cohen et al., 2006, p. 255). Tenbrunsel and Messick (2004) indicate that repeated occurrences of unethical behaviors are related to

psychological desensitization, which allows individuals to reduce self-criticism each time an event occurs. Although practitioners reported repeated unethical conduct, it seems that they were desensitized to the immorality of their acts. Moreover, misdiagnosis violates APA Ethical Standard 6.06 (APA, 2002. p. 1068), and it is illegal. However, Cohen et al. (2006) did not discuss this behavior or the other behaviors as dishonorable conduct. Instead, they considered unethical acts as justifiable behaviors done by mental health care professionals who were struggling with *translating* clients' problems into diagnoses *acceptable* to regulations imposed by managed care (Cohen et al., 2006). The current study acknowledges that managed care regulations have put practitioners in a professional bind, but does not camouflage unethical behavior as acceptable.

In their study Kielbasa et al. (2004) acknowledged that managed care research has concentrated on the therapeutic process instead of the diagnostic decisions made by clinicians. These researchers recognized that insurance companies reduce, limit, and deny reimbursement for psycho-diagnostic assessment. However they were unclear if/how the restraints influenced diagnostic assignment and category.

Kielbasa et al. (2004) examined the relationship between payment and diagnosis. Specifically they examined (a) the extent that payment method (out of pocket *vs*. managed care) impacts the probability that a practitioner will assign a DSM-IV diagnosis to a client, and (b) how fee method influences the selection of a specific diagnostic category. Seven hundred fifty members of APA Division 42 (Psychologists in Independent Practice) responded to a demographic questionnaire, read two vignettes, and answered diagnostic questions about the vignettes. The first vignette described a fictional client with symptoms of depression, and the second described a fictional client with

symptoms of anxiety. The vignettes included non-symptom background information to make the clients as realistic as possible. The clients presented with symptoms and severities that were *just-at* diagnostic thresholds. Half of the participants received surveys that indicated that the services would be paid for via out-of-pocket, and the other half of the participants received surveys that indicated that the services would be paid for via a managed care reimbursement. After each vignette, all participants answered two questions: (a) "Would you assign this client a DSM-IV diagnosis?" and (b) "If you answered 'yes' to the previous question, what specific diagnosis would you provide?" For the first question, the participants were limited to answering *yes* or *no*, and for the second question participants were provided with a blank space to indicate a specific diagnosis.

Of the 750 members of Division 42 surveyed, 188 participants responded with usable data, representing a 25.06% return rate (Kielbasa, at al., 2004). Reported demographic information indicated that most practitioners: (a) identified as white males, (b) had earned Ph.D. degrees, (c) specialized in clinical psychology, (d) endorsed an eclectic theoretical orientation, and (e) worked in solo private practice. Data analyses used frequency and chi-square statistics (Kielbasa et al., 2004). Kielbasa et al. (2004) found that client payment method was positively correlated with diagnostic decisions made by clinicians. Compared to clients who paid out-of-pocket, clients who paid via managed care were (a) more likely to be diagnosed with a DSM-IV disorder, and (b) more likely to be diagnosed with an adjustment disorder. These two findings were common across the two types of presenting symptoms: anxiety and depression. Specifically, the fictional client who presented with anxious symptoms and paid via

managed care was 10 times more likely to be assigned a diagnosis than the out-of-pocket anxious counterpart. The fictional client who presented with depressive symptoms and paid via managed care was 3 times more likely to be assigned a diagnosis than the out-of-pocket depressed counterpart. Keilbasa et al. (2004) speculated that DSM-IV diagnoses were assigned to individuals who paid with managed care more frequently than to individuals who paid out-of-pocket because managed care companies require a diagnosis to validate the necessity for treatment and subsequent payment for services provided.

While the results demonstrated a positive relationship between assignment of diagnosis and method of payment, research limitations constricted the results. The study materials included short vignettes instead of lengthier descriptions or information about real individuals, which would have made the clinical issues more realistic. Second, the presenting issues were limited to anxiety and depression, which limits the generalization of the results across other DSM-IV diagnoses and categories. Third, the vignettes did not control for the possibility of ambiguous DSM-IV diagnoses, such as adjustment disorder. Ambiguous diagnoses encompass a variety of symptoms. Fourth, of the individuals surveyed only 25.06% provided useable data, which is considered a low response rate. Low response rates may be attributed to an assortment of factors and confounding variables. It is always important to consider the characteristics and information of non-responders and responders who reported unusable data. This consideration is especially important when thinking about the results of this study, because almost 75% of those surveyed did not response or responded with unusable data. The characteristics of these non-responders may have provided additional information and/or altered the results significantly.

In a follow-up study, Pomerantz and Segrist (2006) explored client payment method further by using vignettes that described clients whose symptoms were less severe than those in mentioned in Kielbasa et al. (2004). Pomerantz and Segrist (2006) focused specifically on high functioning individuals who were in need of treatment but whose symptoms did not meet DSM-IV diagnostic criteria. The researchers built directly on Kielbasa et al.'s (2004) study design by comparing clients who presented with identical symptoms, and who differed only in regard to their method of payment. The study evaluated the influence of fee method on diagnostic decisions when considering clients who experience symptoms that fall *just* below the threshold of a DSM-IV disorder (Pomerantz & Segrist, 2006).

Pomerantz and Segrist (2006) surveyed 1,000 members of APA's Division 42, using a survey formatted in a similar manner to the one used by Kielbasa et al. (2004). The survey included demographic questions, two vignettes, and four questions about diagnostic decisions. Half of the surveys indicated that the fictional clients were paying out-of-pocket, and the other half indicated that the fictional clients were paying via managed care (Pomerantz & Segrist, 2006). The vignettes described two clients: one with depressive symptoms, and one with anxious symptoms. The fictional individuals presented with symptoms that were sub-threshold to meet the criteria for a DSM-IV diagnosis, specifically: (a) number of symptoms were insufficient, (b) presenting problems were too short in duration, and (c) the individuals' global assessment of functioning and daily living experiences were indicated to be "high". Unlike Kielbasa et al. (2004), researchers included client statements such as "no specific triggers" for the

symptoms to attempt to indicate that an adjustment disorder diagnosis was an inappropriate diagnosis (Pomerantz & Segrist, 2006, p. 256).

Two hundred seventy five participants responded to the survey, representing a 30.25% return rate. Reported demographic information indicated that most practitioners: (a) identified as white males, (b) had earned Ph.D. degrees, (c) specialized in clinical psychology, d) endorsed an eclectic theoretical orientation, and (e) worked in individual private practices. Pomerantz and Segrist (2006) used frequency and chi-square statistics for data analyses. Psychologists gave diagnoses to clients who paid via managed care three times more frequently compared to clients who paid out-of-pocket. Interestingly, almost 10 % of the participants included voluntary comments about needing to diagnose the clients to be reimbursed by third party payers (Pomerantz & Segrist, 2006). The pilot study completed for this dissertation (Racanello, 2010) used a paper survey format instead of an online survey format to attempt to gain similar anecdotal information.

Pomerantz and Segrist's (2006) research suggests that even when clients do not meet criteria for a mental disorder, their method of payment has a substantial impact on the clinical decisions made by the psychologist. This finding was initially established in the Kielbasa et al. (2004) study with fictional clients who presented with more severe symptoms. Pomerantz and Segrist (2006) purported that both the quantitative data and the unsolicited qualitative comments can be generalized to clinicians who work with clients in *real life*. Managed care payment was positively correlated with practitioners more frequent assignment of DSM-IV diagnoses and up-coding (Pomerantz & Segrist, 2006).

Although the results demonstrated a positive relationship between assignment of diagnosis, even when one is not merited, and client's method of payment, research

limitations constrict the findings. Pomerantz and Segrist (2006) reported that the vignettes were short and possibly did not reflect lengthier descriptions and information that is provided by *real clients*. The clients presented with anxiety and depression symptoms only; the findings may limit the generalization of the results across other DSM-IV diagnoses and categories. Further, the participants were a subset of Division 42 members, and may not be truly representative of the entire division membership or general profession (Pomerantz & Segrist, 2006).

Pomerantz and Segrist (2006) did not include DSM-IV criteria in the participants' study material; thus it is unclear why participants diagnosed the clients incorrectly. It is possible that they were not familiar enough with diagnostic requirements to assign a correct diagnosis. Although unsolicited anecdotal information about third party reimbursement was included by participants, only 9.68% wrote such comments. To correct for possible practitioner diagnostic limitations, the dissertation survey materials included: (a) questions that inquire about practitioners' knowledge of DSM-criteria, and (b) DSM-IV criteria to attempt to ensure that participants are aware of whether fictional clients meet/do not meet diagnostic criteria.

Lowe, Pomerantz, and Pettibone (2007) followed up the work of both Kielbasa et al. (2004) and Pomerantz and Segrist (2006). They examined psychologists' diagnostic assignments of fictional clients who presented with sub-threshold symptoms of social phobia and attention deficit/hyperactivity disorder (AD/HD). Researchers attempted to replicate the study design of Kielbasa et al. (2004) and Pomerantz and Segrist (2006). Lowe et al. (2007) used the same survey design but altered the symptoms from anxiety and depression to those previously mentioned. Participants answered demographic

questions, read two vignettes, and answered two diagnostic questions. The diagnostic questions were: (a) "Would you assign this client with a DSM-IV diagnosis?" and (b) If you answered 'yes' to question 1, what specific diagnosis would you assign?" (Lowe et al., 2007, p. 85-86). The first vignette described a client with sub-threshold social phobia symptoms, and the second described a client with sub-threshold AD/HD. The clients' problems were described as (a) occurring *sometimes* as opposed to *perpetually*, (b) being *reasonable* instead of *unreasonable*, and (c) interfering with daily life *minimally* instead of *drastically*. Each vignette deliberately included statements to indicate that a diagnosis of adjustment disorder was inappropriate. Half of the sets of vignettes indicated that the clients were paying out-of-pocket, and the other half indicated that the clients were paying via managed care. Researchers counter-balanced the order of the vignettes on the surveys to attempt to ensure the statistical quality of the data. To enable reliable comparison between the two previous studies, Lowe et al. (2007) surveyed members of APA's Division 42.

Lowe et al. (2007) solicited 400 participants to participate in the study; 114 participants returned useable data representing a 31.9% return rate. Reported demographic information indicated that most practitioners: (a) identified as white males, (b) worked in solo independent practice, (c) specialized in clinical psychology, (d) had earned Ph.D. degrees, (e) endorsed an eclectic/integrative theoretical orientation, and (f) worked in settings described as *suburban*.

The authors used frequency and chi-square statistics to analyze the data. Results substantiated the work of both of the previous studies by Kielbasa et al. (2004) and Pomerantz and Segrist (2006). Again, payment method had a significant influence on

diagnostic assignments. When examining clients' method of payment, authors found that those paying via managed care were more likely to be assigned a DSM-IV diagnosis, compared to those paying out-of-pocket. Clients who presented with symptoms of social phobia who paid via managed care were more than five times more likely to receive a DSM-IV diagnosis when compared to identical clients who paid via out-of-pocket. For the social phobia vignettes, 92.2% of the clients paying via managed care were assigned a diagnosis, but only 69.8% of clients paying out-of-pockets were assigned a diagnosis. Clients paying via managed care who presented with symptoms of AD/HD were almost three times more likely to be assigned a diagnosis compared to identical clients paying out-of-pocket. For the ADHD vignettes, 51.0% of managed care clients were given a diagnosis, whereas 27.1% of out-of-pocket clients were given a diagnosis (Lowe et al., 2007). As reported earlier, these data verify the findings of Kielbasa et al. (2004) and Pomerantz and Segrist (2006); and this research expanded the previous findings to include additional presenting problems. Even though the problems of the fictional clients fell short of the DSM-IV criteria, clients paying via managed care were more likely to be given a diagnosis compared to those paying out-of-pocket.

Lowe and colleagues' (2007) research results further supports the positive relationship between assignment of diagnosis and client's method of payment; however research limitations reduce the ability to generalize the findings. The vignettes were short and not as realistic as lengthier descriptions and information provided by real clients. The clients presented with social phobic symptoms and AD/HD; although the findings extended those found in other studies to other diagnoses (Kielbasa et al., 2004: Pomerantz & Segrist, 2006), the data remain limited to generalization across other DSM-

IV diagnoses and categories. Further, the participants were a subset of Division 42 members, and may not be truly representative of the division or larger profession (Pomerantz & Segrist, 2006). The vignette for the individual who presented with AD/HD described the client as pediatric. Although a specific quantitative value was not reported by the researchers *several participants* wrote unsolicited notes that they were uncomfortable assessing a pediatric patient (Lowe et al., 2007). Thus, it is impossible to estimate how, or if, the data would have been altered if the participants were asked to evaluate clients they considered within populations of their professional competence.

The authors did not include DSM-IV criteria in the study's material, thus it is unclear why participants diagnosed clients incorrectly. It is possible that misdiagnosis was due to the participants being unfamiliar with diagnostic requirements. In consideration of this limitation, the dissertation survey materials included questions that inquired about practitioners' knowledge of DSM-criteria, as well as the specific diagnostic criteria. This was an attempt to ensure that participants were aware that fictional clients met/did not meet diagnostic criteria. Lowe et al. (2007) admitted that the research lacked inquiry into the decision process of the participants' clinical judgments. It is possible clinical judgment information would have provided valuable insights about the significant findings. Both the pilot study (Racanello, 2010) and the dissertation included inquiry questions to attempt to understand the cognitive process that leads to faulty diagnostic decisions.

The pilot study (Racanello, 2010) for this dissertation built on previous research (Kielbasa, et al., 2004; Lowe et al., 2007: Pomerantz & Segrist, 2006), specifically by replicating the study designs and attempting to broaden the results. Because Lowe et al.

(2007) noted reasons for diagnostic assignments as a limitation, the pilot queried participants about why they assigned a DSM-IV diagnosis to fictional clients when the individuals' presenting symptoms did not meet diagnostic criteria. Additionally, the study attempted to understand the point at which a client would present with too few symptoms to be assigned a diagnosis by a practitioner, regardless of the method of payment (Racanello, 2010).

Each participant received an information sheet and a survey. The survey included 12 demographic questions, one vignette describing a child with oppositional symptoms, and seven questions that related to the vignette, diagnostic decisions, and the APA ethics code. There were three forms of the survey, and each presented a client with sub-threshold oppositional symptoms. Noting the limitations of other studies (Kielbasa et al., 2004; Lowe et al., 2007; Pomerantz & Segrist, 2006), the survey provided additional information about the client and his family to make the individual appear to be as realistic as possible.

All three forms of the vignette reported that the family would be paying for treatment via their managed care plan. All forms of the vignette described a pediatric client with oppositional symptoms that did not meet DSM-IV criteria for the required duration of time to be assigned the diagnosis of Oppositional Defiant Disorder. The DSM-IV requires that the symptoms and oppositional behaviors to be present for at least six months. All three forms of the survey indicated that the symptoms were present for only "four to five months". The three forms differed from each other based on the number of symptoms that the client presented with, specifically: (a) in form A the client presented with four symptoms: (b) in form B the client presented with three symptoms:

and (c) in form C the client presented with two symptoms. The client's presentation was described specifically not to meet the criteria for an adjustment disorder. After each vignette the participants were asked: (a) "Would you assign this client a DSM-IV diagnosis?" (b) "If you answered 'yes' to Question 1, what specific diagnosis would you assign?" (c) "If you answered 'yes' to Question 1, why did you assign the diagnosis?" and (d) "If you answered 'yes' to Question 1, how important do you feel it is that this child receive treatment?" (Racanello, 2010).

The study employed a convenience sample. Of the 98 people surveyed, there were 30 respondents, representing a 32.67% return rate. Reported demographic information indicated that most practitioners: (a) identified as females, (b) worked in independent private practice, (c) specialized in clinical psychology, (d) had earned Ph.D. degrees, and (e) endorsed a cognitive-behavioral theoretical orientation (Racanello, 2010). Data were analyzed used frequency and chi-square statistics. The practitioners assigned clients a variety of disorders, including adjustment disorder, even though the client specifically did not demonstrate the maladaptive behaviors to meet the diagnostic criteria for an adjustment disorder.

Interestingly, of the participants who admittedly diagnosed clients improperly, over one-third concurrently indicated that they were at least moderately familiar with the APA ethics code. Further, greater than half of these individuals reported that they *always* abided by APA ethical standards. Thus, practitioners who reported that they acted ethically 100% of the time concurrently demonstrated and reported unethical clinical behaviors. This finding was of particular interest for this dissertation study, because it suggests that participants were familiar enough with the ethics standards to know that it

was unethical to diagnose a client whose behavior did not meet criteria, but they did it anyway. Practitioners who diagnosed the clients were asked, "Why did you assign the diagnosis?" The response "required by managed care" was indicated by 41.6 % of the participants who assigned a diagnosis. It seems that these individuals acted in a self-interested manner, allowing personal needs/wants to influence their perception of the situation (Racanello, 2010). The data from the pilot (Racanello, 2010), further substantiates the work of the three studies previously described (Kielbasa, et al., 2004; Lowe et al., 2007; Pomerantz & Segrist, 2006). Pilot data also broaden the topic by attempting to gauge participants' reasoning for assigning incorrect diagnoses. This was a focus of the dissertation.

Racanello's (2010) pilot study further suggests that a positive relationship exists between assignments of diagnoses, even when not merited, and clients' method of payment. The study also demonstrated that even when clients present with symptoms that are far below diagnostic criteria, practitioners will likely assign faulty diagnoses if the client is paying via managed care. Further, it demonstrated that some practitioners report that they always act ethically, but concurrently demonstrate and report unethical clinical behaviors with regard to managed care.

With that said, the results of this study have several substantial limitations. The limitations reduce the generalizability of the findings. The *clients* in the study's vignettes paid with insurance only, as opposed to other methods of payment, such as out-of-pocket. The number of participants was low, thus all results should be considered with caution. The vignettes were written with the intent of being as realistic as possible, but did not provide the amount of thorough information given by *real* clients. The symptoms were

intentionally below threshold for a diagnosis of Oppositional Defiant Disorder, but they may be considered plausible for meeting the criteria for Disruptive Behavior Disorder. Of the participants who diagnosed the fictitious client, 33% specifically indicated Disruptive Behavior Disorder as their diagnosis. This was an overt oversight on the part of the researcher, and it was resolved in future work. The range of the presenting problems was limited to a pediatric client demonstrating oppositional and defiant symptoms, thus is limited to this set of presenting symptoms and a pediatric population.

Further, participants were not asked to report their knowledge of the DSM-IV. Therefore when participants indicated that they would diagnose clients, it was unclear if they were doing so specifically because of managed care reasons, and/or because they: (a) were not familiar enough with diagnostic criteria to correctly assign a diagnosis, and/or (b) had different reason(s) for providing diagnoses. While the participants were asked how familiar they were with the APA ethics code, the information provided was qualitative: *very familiar, familiar, moderately familiar, and unfamiliar*. The dissertation survey asked this same question, and also asked participants the specific number of years that have elapsed between now and the last time they completed an APA ethics and law course/workshop. Albeit these and other limitations, the results of the study add to the evidence that individuals who present with very few symptoms may be diagnosed by a practitioner for the purpose of managed care. The current research attempted to address each of the limitations described.

With the exception of the pilot study (Racanello, 2010), previous research (Kielbasa et al., 2004; Lowe et al., 2007; Pomerantz & Segrist, 2006) did not ask participants why they chose to give diagnoses to clients who did not meet criteria.

Readers should note, however, that assigning a false diagnosis is unethical behavior regardless of the reason for doing so. This leads to the question: How can psychologists who say they behave ethically reconcile the unethical behavior of assigning clients diagnoses for which their symptoms do not meet criteria? It seems that a disparity exists between psychologists' self-beliefs that they are ethical and their demonstrations of unethical behaviors. A disconnect between perception and action leads to cognitive dissonance (Festinger, 1957).

Cognitive Dissonance and Distortions

In 1957, Leon Festinger presented dissonance theory, which purports that pairs of cognitions can be related to each other; the relationship can be either consonant or dissonant. When cognitions are consonant, thought A is subsequent to thought B. When cognitions are dissonant, thought A is not subsequent to thought B, the opposite of thought B is what follows the other. When dissonance occurs in individuals, they feel psychological discomfort, and are motivated to reduce the dissonance. Reduction of dissonance occurs when: (a) dissonant cognitions are removed, (b) new consonant cognitions are added, and/or (c) the importance of the dissonant cognition is either reduced or increased (Harmon-Jones & Mills, 1999).

When abstract rules are applied to specific situations, the ambiguity authorizes the individual to use an indefinite amount of abstract logic and personal judgment. According to Bersoff (1999), normative social standards are loosely defined, thus social standards are ripe for manipulation by individuals who are motivated by personal gain. Standards and norms of behavior are often adjusted by time, setting, and social circumstances. The result is further ambiguity of social norms, which leads to several consequences. The two

consequences that are pertinent to this research are: (a) individuals are able to substantiate self-interested behaviors by convincing themselves that the action is an exception to the pertinent social standard, and (b) if/when an action seems to be unethical behavior, because *exceptions* are common, it is rare that individuals will deem the action immoral (Bersoff, 1999).

Individuals are motivated to substantiate what they want to be factual before considering alternative explanations. Self-interest biases alter the perception of situations easily. When information is accepted selectively, considered morally acceptable, and other information is added and integrated, the perception of the data becomes more immune to disconfirmation. Erroneous decision making distorts attribution perceptions that interpret future information (Bersoff, 1999).

Dissonance between self-reported morality and ethical conduct stems from two types of cognitive distortion processes: miscontrual (Bersoff, 1999), and self-deception (Tenbrunsel & Messick, 2004). Thus, it is suggested that self-interest via misconstrual (Bersoff, 1999) and self-deception (Tenbrunsel & Messick, 2004) corrupt moral judgment.

Miscontrual. Individuals act unethically because they: (a) act on more significant personal obligations and/or desires, and/or (b) yield to temptations. Usually, moral theorists study morality and ethical decision processes after individuals determine if events are of an ethical nature. Consequently, there has been sparse examination of *how* individuals determine if an event is a *moral one or not* (Bersoff, 1999).

Bersoff (1999) purported that individuals may fail to realize when specific situations require moral decision-making; this is considered miscontrual. The

misconstrual model purports that immoral behavior is not a result of moral judgment failing. Unethical behavior occurs because self-serving interests corrupt moral judgment. According to Bersoff, when individuals perceive events, cognitive processes may be compromised, and the individuals may be tempted to behave unethically. If an individual's self-serving interests are realized, before he determines if an event is of an ethical nature, he will act in a self-serving manner (Bersoff, 1999). Additionally, Bersoff (1999) explained that when an individual fails to recognize an issue to be of an ethical nature, it is possible that he did not perceive the ethical nature of the situation due to his self-interests. Self-serving cognitions distort perceptions of events. Personal interests may be responsible for: (a) under-estimating the negative effects of an immoral action, (b) failing to realize that certain actions are unethical, (c) miscalculating the consequences of unethical actions, and/or (d) amplifying the benevolent value of actions.

Miscontrual occurs via a two step-process: (a) information is obtained and comprehended based on the conclusion that the individual is motivated to attain, and then (b) the intended conclusion is reached without sufficiently considering alternative hypotheses and conclusions (Bersoff, 1999). Although miscontrual of situations occurs, it is bound by some circumstances: (a) a valid belief that the justification and rationalization for the action are well-founded, (b) little moral ambiguity about the justification for the action, and (c) little contortion of reality (Bersoff, 1999). Self-deception facilities the construal/miscontrual of situations. Self-deception allows moral aspects of events to be removed and appear to be devoid of ethical constraints (Tenbrunsel & Messick, 2004).

Self-deception. Self-deception is the process that occurs when an individual behaves according to self interests, yet believes that he is abiding by his moral principles. Self-deception causes the ethical characteristics of a situation to fade via four conditions: *language euphemisms, the slippery slope of decision making, errors in perceptual causation, and constraints induced by the representations of self* (Tenbrunsel & Messick, 2004).

Language euphemisms are narratives that individuals tell themselves about unethical behaviors. The narratives are edited accounts of the actual events, but are missing all of the moral connotations. When the language of issues is *edited* in a harmful way, unethical and corrupt conduct (e.g., recreational drugs, white-collar crime, and politically incorrect) becomes *acceptable*. When individuals use language circumlocution, they do not perceive their behaviors as questionable because their immorality is disguised (Tenbrunsel & Messick, 2004).

Edited description of a behavior may justify it, allowing the behavior to become *socially acceptable*. When this occurs, individuals avoid the complexity that accompanies ethical decisions and use altered cognitive schemas. The ethical characteristics of the issue have *faded* (Tenbrunsel & Messick, 2004).

The *slippery slope of decision making* refers to two processes: (a) repeated occurrences and (b) induction. Reoccurral is related to psychological desensitization. Psychological desensitization allows individuals to reduce self-criticism each time an event occurs.

With regard to this research logical induction occurs when practitioners alter their practice very slightly each time they make diagnostic decisions that do not meet criteria.

Individuals use previous ethical reference points to judge their current performance. The *new* practice is so slightly altered that it appears to be qualitatively unchanged from previous actions. If in the past an individual acted ethically, he will believe that he continues to do so. When an individual's practices are ethically altered minutely from situation to situation, the actions, although slightly different from those before, will lead to more frequent and intense unethical actions (Tenbrunsel & Messick, 2004).

Outcomes are complicated; thus it is very difficult to parse out step-wise decision components, and individuals are fallible and act self-interestedly. Complicated outcomes allow room for perceptual causation errors and misconception about ethical responsibility. Erroneous perception allows individuals to: (a) detach from moral circumstances, (b) believe the problem is due to fallibilities in the system, but not due to *problems with self*, and (c) conclude that the responsibility belongs to another individual. Perceptual errors allow the ethical characteristics of an event to *fade*. When fading occurs, the moral demands of a situation are diluted and removed from the individual's immediate experience. Fading is when the ethical aspects of a decision disappear. The individual self-deceives and behaves in a self-interested manner, while falsely believing that he upheld moral principals (Tenbrunsel & Messick, 2004).

Theories suggest that acceptance of dissonance between self-reported personal ethics and unethical conduct occurs because of cognitive distortion: miscontrual (Bersoff, 1999) and self-deception (Tenbrunsel & Messick, 2004). Self-interest via misconstrual (Bersoff, 1999) and self-deception (Tenbrunsel & Messick, 2004) corrupt individuals' moral judgments, and reduce dissonance. Dissonance reduction is only pertinent to an individual's thoughts. The theories instigated several follow-up questions, one of which

is of particular interest to the current study: Is an individual's affect altered when he considers himself ethical but acts unethically?

Motivated Reasoning

The dissonance reduction research is lacking, because it does not question *how* individuals' cognitive processes change when dissonance is reduced. The theories previously mentioned attempt to reconcile the ways an individual is able to express that he is A, but then able to do B (Bersoff, 1999; Tenbrunsal & Messick, 2004) via cognition only (Kunda, 1999). To reduce dissonance between beliefs and behaviors, individuals need to adopt attitudes that are aligned with the endorsement of negating constructs. Motivated reasoning theorists suggest that individuals come to conclusions that they *want to reach* because they are personally *motivated* to do so. Humans process information by cognitive schemas, including self-schemas. Self-schemas filter information *selectively*; thus self-schemas enable individuals to gather evidence and information that supports the *hoped for conclusion* (Aronson & Reilly, 2006).

Aronson and Reilly (2006) examined the role of self-schemas and motivated reasoning in personality assessment. When individuals perceived the desirability of certain traits, they selectively search their memories to find instances when they acted in the accordance with the desired traits. The individuals are motivated to reconcile and/or change their self-concept to endorse the desired characteristic. Motivated reasoning occurs easily when individuals possess memories that reflect both sides of the desired trait (Aronson & Reilly, 2006).

Aronson and Reilly (2006) conducted a study to understand if applying for a job would motivate applicants to endorse a specific schema. Once participants adopted the

desirable schema, researchers examined if the participants would reflect their behavior according to the schema, even if inaccurate. Specifically, the study examined the influence of self-schemas and motivated reasoning on responses to a personality test. Participants responded to personality tests under neutral and non-neutral (job application) conditions. After individuals completed the personality inventory in the job applicant condition, they completed a personality questionnaire. When participant responses were compared, the validity of the personality responses in the neutral condition was higher than the validity of the personality responses in the job applicant condition. When individuals responded to the questionnaire in the job application condition, they employed inaccurate self-schemas and selective memory searches to increase their desirability as a job applicant (Aronson & Reilly, 2006).

With regard to the pilot (Racanello, 2010) and current study, it seems that participants were motivated to use self-schemas to report that they are ethical 100% of the time. When answering the survey item in the pilot study, which specifically queried individuals' ethical standards, it seems that individuals were motivated to reduce cognitive dissonance to enable them to report that they act ethically 100% of the time but simultaneously reported unethical behavior. Further, it is possible that individuals used a selective memory search, and thought of times when they were ethical. To explore this area further, participants in the dissertation study were asked to comment on two scenarios that describe unethical behavior. The first scenario described a situation that is generally unethical, stealing an item from a grocery store. The second scenario described a situation that is professionally unethical, changing dates on an insurance form. Following each scenario was a forced choice item which asked participants if the

behavior described is ethical or unethical. It was hypothesized that a substantial number of individuals who report being ethical 100% of the time, but demonstrate unethical professional behaviors, will report 'yes' to the first but 'no' to the second scenario. If responses were returned in this format and the items were sensitive enough to examine motivated reasoning, it would have suggested that the individuals may have employed schemas that aligned with their own perceptions and behaviors, to determine if the scenarios were unethical or not.

Unethical Characteristics Associated with Unethical Decision Making

Unethical clinical decisions are strongly related to self-interest and negative outcomes (Tenbrunsel & Messick, 2004), such as legal trouble. Intentional misdiagnosis is considered fraudulent behavior (APA, 2002). Previous studies indirectly suggest that (a) some psychologists report that acting fraudulently with regard to managed care is *worth it* to fulfill personal self-interest, and (b) some psychologists do not perceive unethical behavior with regard to managed care as *truly unethical*. Thus, it is important to understand: (a) Who would consider unethical behavior worth it? (b) Do these individuals have specific personality traits? (c) Do differences exist between the personality traits of individuals who report personal ethics but act unethically compared to individuals who report aligned morally standards and behaviors? Unethical decisions are related to specific personality characteristics associated with low emotional intelligence (Meser-Magnus, Viswesvaran, Deshpande, & Joseph, 2010), high narcissism, and low empathy (Brown, Sautter, Littvay, Sautter, & Bearnes, 2010; Monro, Bore, & Powis, 2005).

Relationship of narcissism and empathy to ethical conduct. Munro et al. (2005) conducted two studies that examined personality characteristics associated with

unethical choices and behaviors. The aim of the research was to establish the validity of the Narcissism-Aloofness-Confidence-Empathy scale (NACE), and to determine if correlations existed between NACE scores and moral orientation and cognitive ability. The first study surveyed first year medical students from two universities (n = 237). All participants completed the following scales: NACE (Monro et al., 2005), sections of the 16PF (Cattell, Eber, & Tatsuoka, 1970), Five-Factor Theory 20-item scale (Goldberg 1992, 1999), the 33-item Emotional Intelligence Scale by Shutte et al. (1998), and the short form of the Marlowe-Crowne Social Desirability Scale (Strahan & Gerbasi, 1972). A factor analysis of the data yielded results that suggested that narcissism and empathy are likely separate, but not opposite, personality dimensions (Monro et al., 2005).

In the second study, 510 participants completed measures of extraversion, neuroticism, psychoticism, sensitivity to punishment and rewards, and interpersonal relationship style: NACE (Monro et al., 2005), Five-Factor Theory 20-item scale (Goldberg 1992, 1999), Sensitivity to Punishment and Sensitivity to Reward Questionnaire (Torrubia, Avila, Molto & Caseras, 2001), and Horney-Coolidge Type Indicator (Coolidge, 2001). A factor analysis again confirmed that narcissism and empathy are distinct personality dimensions. Further, the data indicated that narcissism and empathy are related to unethical behavior. Narcissistic aggression was specifically correlated with undesirable behaviors. This type of narcissism is defined as an individual's motivation to pursue his own wants in spite of the needs of others (Munro et al., 2005).

Brown et al. (2010) also examined the relationship between unethical decisions and personality characteristics, specifically low empathy and high narcissism. In this

research narcissism was considered with regard to an individual's perception of situations that are related to satisfaction of needs; specifically a person with high narcissism perceives more situations in a selfish and egocentric fashion when compared to the perceptions of individuals with low self-reported narcissism scores. Researchers defined empathy as the emotional capacity that individuals demonstrate when they place themselves in another's position and situation (Brown et al., 2010).

Three hundred nine business students were surveyed, and 244 participants responded with useable data; this represents a 79% response rate. Surveys included demographic questions, the Phares and Eriskine Selfism Test (1984), questions that examined empathetic patterns, and a hypothetical ethical dilemma with follow-up questions. Brown et al. (2010) stated four hypotheses, two of which are of particular interest to the current work: (a) high narcissism would be related to unethical decisions; and (b) high empathy would be related to ethical decisions. Concurrent with the hypotheses, personality traits were predictive of individuals' demonstrations of unethical behavior. Specifically, unethical behavior was correlated positively with low levels of empathy and high levels of narcissism. The study further suggests that personality traits are important and fundamental predictors of ethical behavior (Brown et al., 2010).

Rationale and Hypotheses

Essentially, managed care puts therapists in a bind, because they act as agents for two different principals (i.e., their clients and the insurance companies). Therapists must gather truthful data to provide appropriate services to their clients. Therapists also need to provide a diagnosis to the insurance payer to receive remuneration for their services rendered. Given the huge asymmetries of information---both principals have serious lacks

of information of different kinds, and partially divergent interest---it is little wonder so much fraud occurs.

The reviewed research demonstrates that clinicians tend to assign DSM-IV diagnoses to clients who pay via managed care even when these individuals present with fewer symptoms than required by the DSM-IV. The current study was an attempt to further understand: (1) practitioners' diagnostic decisions for clients paying via managed care when they present with too few symptoms for a clinician to assign a DSM-IV diagnosis, (2) why clinicians are assigning DSM-IV diagnoses to clients when they present with symptoms that do not meet diagnostic criteria, (3) the levels of empathy and narcissism characteristics associated with professionals who demonstrate unethical behaviors related to managed care, and (4) possible motivated reasoning schemas demonstrated by professionals who demonstrate unethical behaviors related to managed care.

Based on previous research (Kielbasa, et al., 2004; Lowe et al., 2007: Pomerantz & Segrist, 2006; Racanello, 2010) this research was designed with the following hypotheses:

HO1: A substantial number of the clinicians will assign a DSM-IV diagnosis to the clients paying via managed-care even when they present with sub-threshold symptoms

HO2: A substantial number of practitioners will assign a faulty diagnosis to be r reimbursed by third party providers

HO3: Within the group of practitioners who assign unmerited DSM-IV diagnoses, a significant number of practitioners will report that the are ethical 100 percent of the time

HO4: Practitioners who assign unmerited DSM-IV diagnoses, will have higher levels of narcissism and lower levels of empathy than practitioners who do not assign unmerited diagnoses

HO5: Significantly more practitioners who assign unmerited DSM-IV diagnoses that practitioners who do not will state that the individual in the reasoning scenario who acts unethically in a managed care situation acted ethically

Chapter III

Method

This chapter presents the methodology that the study used to examine the relationship between psychologists involvement in managed care and psychologists' personality characteristics and use of incorrect schemas. The chapter begins with a description of the selection and characteristics of participants, followed by sections about: description of the instrument, procedure, and data analysis.

Participant Selection and Demographic Information

After receiving approval from the Institutional Review Board of the City University of New York Graduate School and University Center, I solicited participation from practicing mental health practitioners. I specifically asked APA permission to send an email (see Appendix A) to members of Divisions 12, 29, and 42, the Societies of Clinical Psychology, Psychotherapy, and Psychologists in Independent Practice respectively. These Divisions have members who engage in clinical practice and/or training. Readers should note that membership in these Societies may signify greater knowledge and use of the DSM-IV criteria and knowledge of APA ethics compared to unaffiliated clinicians. Permission was also granted to recruit members from New Jersey State Psychological Association, and the same emails were sent to the members of this professional organization. Additionally, existing participants were asked to forward the study's information including the email to other professionals who might have been interested in participating in this study. The email which participants received included: (a) an information sheet that describes the study and informs participants of their rights, and (b) a link to the questionnaire.

To ensure confidentiality, participants were not asked to provide any identifying information. Participants who had questions about the study and/or wanted to review the results once the study was completed were able to contact me directly via email. The email did not link to participants' questions and survey responses, further ensuring participant privacy and confidentiality.

At least 100 participants were needed to respond to the survey with useable data to enable me to complete the anticipated statistical comparisons. This is the sample size needed to detect a medium effect size at the $p < .01$ level of significance (Cohen, 1992). The email was sent to approximately 4000 individuals, of which 101 completed the survey. The return rate was 2.5%. An additional 56 individuals started the survey but did not provide usable data. By and large, most respondents answered the demographic variables, with 80% having no more than two missing responses ($N = 80$). However, some notable variables had more missingness than did others, discussed below.

Participant demographics. Participants were asked to report demographic information including: age, gender, highest degree earned, specialization during education, and theoretical orientation. Table 1 presents the participant age range information.

Table 1

Participants' Age Ranges

Age Range	*N*	%
-25 years	1	1.00
25-35 years	26	26.00
36-45 years	22	22.00
46-55 years	16	16.00
56—65 years	23	23.00
66-75 years	10	10.00
+75 years	2	2.00

Note. N = 100

From Table 1 we see that the plurality (26%) of the participants reported that they are between 25-35 years old. Compared to information reported by a study conducted for the APA (Milchalski & Kohout, 2011), the age range of the current participants may not be representative of the age distribution of the population of practicing psychologists. Specifically, Michalski and Kohout reported that the largest percentage of psychologists were over 56 years of age. It is possible that Michalski and Kohout's data differed from the information found in the current research, because their data were collected in two formats: paper and pencil and online. This dissertation's participants responded online only. It is possible that older practitioners make less use of the internet, and therefore were not included in the current study. Also, information reported by the APA Center for Work Force Studies in the 2010 Member Profile Report again suggests that the age range of the current participants may not be representative of the age distribution of the

population of current APA members. APA reported that the majority of members is between 60-64 years of age (APA, 2010).

Table 2

Participants' Gender

Gender	*N*	%
Female	66	67.35
Male	32	32.65

Note. *N* = 98

From Table 2 we see that most (67.35 %) of the participants reported that they are females. Two participants did not report their gender. The information from the current study demonstrates a similar pattern to that reported by Michaelski and Kohout (2011) and APA (2010) with regard to psychologists' gender. Specifically, a higher percent of the sampled psychologists are females. The information from the current study, however, demonstrates a greater difference between the percentage of females and males (34.7%) than that (16.3%) found by Michalski and Kohout, and that (14.3%) reported by APA (Please Note: Throughout their reporting Michalski and Kohout reported percentages to the nearest whole number and at times to the tenths place, which is inconsistent with my practice of reporting percentages to the hundredth place).

Of particular interest to this work is the possible existence of gender and work setting differences. Rupert and Kent (2007) examined gender differences among practicing psychologists, and reported that the male and female psychologist do not experience significant variation in their work settings, including the percentage of manage care services that they provide.

Table 3

Participants' Highest Degree Earned

Terminal Degree	*N*	%
Ed.D.	3	3.23
Ph.D.	55	59.14
Psy.D	14	15.05
Other	21	22.58

Note. $N = 93$

Participants reported the highest degree that they had earned in the area of psychology and/or mental health services. Most frequently (59.14 %), participants reported that they earned a Ph.D., as opposed to Psy.D. (15.05%), Ed.D. (3.23%), or other (22.58%) degrees. Two participants chose to not report their highest degree earned. Participant answers from the current study about their highest degree earned followed the same pattern as the response reported by practitioners in Michalski and Kohout's (2011) study and the APA Member Profile Report (2010). Specifically, both of the other samples reported the greatest number of degrees as Ph.D., followed by Psy.D., followed by Ed.D., and other degrees.

Table 4

Participants' Area of Psychology Specialization

Specialization	*N*	%
Clinical	72	75.00
Counseling	12	12.50
School	7	7.29
Other	5	5.21

Note. *N* = 96

Table 4 shows that most of the participants were clinical psychologists. Clinical psychology is also the specialization that majority of APA members reported to be their professional field (APA, 2010).

Table 5

Participants' Theoretical Orientation

Theoretical Orientation	*N*	%
Behavioral	3	3.06
Cognitive-Behavioral	34	34.69
Eclectic	29	29.59
Psychodynamic	19	19.39
Systems	2	2.04
Other	11	11.22

Note. *N* = 98

Table 5 shows that the participants subscribed to a diversity of theoretical orientations, with a plurality endorsing a cognitive-behavioral orientation.

Table 6

Participants' Work in Private Practice

Private Practice	*N*	%
No	37	37.76
Yes	61	62.24

Note. *N* = 98

Table 6 shows that the majority (*n* = 61, 62.24%) of the participants work in private practice. Of the participants who work in private practice the majority (*n* = 22, 33.48%) reported that they had done so for over 25 years, followed by individuals who reported that they had done so for less than 5 years (*n* = 18, 29.03%).

Table 7

Participants' Participation in Managed Care Plans

Managed Care Participation	*N*	%
Yes	41	46.07
No	48	53.93

Note. *N* = 89

Table 7 shows that less than half the practitioners reported that they participate in manage care insurance plans. It is interesting that 11 participants did not respond to this item. This is the highest number of participants who did not respond to one of the demographic items. One would think that these psychologists know whether or not they

participate in managed care, but chose not to respond to the item. Of those who chose to respond, approximately 46% (*n* = 41) replied in the affirmative and almost 54% (*n* = 48) replied in the negative.

Additionally, a cross tabulation analyzed participants' reported theoretical orientation relative to their participation in managed care plans. Of the practitioners who accept managed care plans, most reported that they endorse an Eclectic (31.71%) or Cognitive-Behavioral (24.39) theoretical orientation. This statistic is of particular interest to this research, because managed care plans often require brief therapy techniques (Brown & Jones, 2005), which are particularly characteristic of certain theoretical orientations, including Eclectic and Cognitive-Behavioral.

Table 8

Participants' Percentage of Practice Under Managed Care Plans

Managed Care Practice	*N*	%
Less than 25%	9	20.00
25-50%	6	13.33
50-75%	10	22.22
More than 75%	20	44.44

Note. *N* = 45

Table 8 shows that of the participants who participate in managed care plans and were willing to share the percentage of participation in such plans. Interestingly, 66.70% of the participants are reimbursed via managed care by more than half their clients. The information reported by the participants seems to be a little higher than those reported in

other studies. In 1996, practitioners indicated in a survey that 35.04% of their current caseload paid via managed care, and in 2001, respondents reported that 46% of their current caseload paid via managed care (Rupert & Baird, 2004).

Rupert and Kent (2007) reported differences between psychologists' work settings and the percentage of managed care clients provided with services. The percentage of managed care clients was greatest when practitioners worked in independent group practice (58.44%), followed by independent solo practice (50.81 %), followed by work at an agency (44.04%) (Rupert & Kent, 2007).

Table 9

Participants' Membership in the American Psychological Association (APA)

APA Membership	*N*	%
Yes	80	82.47
No	17	17

Note. $N = 97$

Finally, the majority of the current sample holds APA membership (see Table 9). Of the participants who reported that they hold APA membership, 60 individuals reported that they belong to specific APA divisions, and 58 of them listed the specific divisions to which they belong. The plurality of responders ($n = 30$) indicated that they belong to Division 12, the Society of Clinical Psychology.

Instrument

An online research questionnaire was the primary data collection measure (see Appendix B) for this research. This measure was developed by me, Dr. Tryon, and Dr. Verkuilen. The research questionnaire included seven measures querying: (a)

demographic information, (b) diagnostic decisions regarding managed care, (c) importance of and adherence to professional ethical standards, (d) knowledge of diagnostic criteria, (e) participant empathy, (f) participant narcissism, and (g) participant use of self-schemas.

The first page was the information sheet. It explained the study and requirements for participation in the study. The participants' completion of the survey was considered their informed consent. The information sheet also explained that I was the principal investigator in the research and that I did not have access to any identifying participant information. The data were not be coded for confidentiality because participants did not include any identifying information when completing the questionnaire. The survey was designed not to allow participants to go back to review answers and/or change answers once they complete the items.

The questionnaire took each participant approximately 25 minutes to complete. At the end of the survey, participants had the opportunity to enter their email addresses into a lottery to receive one of three $25 American Express gift cards. To ensure that participants' email addresses and their responses were not connected, a separate website was provided to them to enter email addresses into the gift certificate lottery.

Demographic information. The survey asked participants questions about their personal and profession background. Demographic items queried participants about their sex and age. Educational items queried participants about their terminal academic degree, area of specialization, and years since they attended a course/workshop that focused on professional ethics and law. Professional items queried participants about their years in

private practice, type of practice, participation in managed care plans, percentage of clients who pay via managed care plans, and theoretical orientation.

Items concerning importance of and adherence to professional ethical standards. Participants responded multiple times during the survey to items about professional ethics. Specifically items queried individuals about: (a) personal adherence to professional ethical standards, and (b) importance of adherence to professional ethical standards. Additionally, participants were asked if they always agree with the ethical standards.

Diagnostic decisions related to managed care clients. The next part of the instrument presented four vignettes about fictional clients. To attempt to ensure the validity and reliability of the vignettes they were peer reviewed by five peers from the researcher's cohort, and subsequent recommended edits were made. To further attempt to ensure the validity and reliability of the vignettes were beta tested by individuals who met the criteria to be study participants and subsequent recommended edits were made. Once these edits were made the vignettes were considered to be *survey ready*.

Half of the participants received surveys indicating that all of the clients are paying for mental health services via managed care; half of the participants received surveys indicating that the fictional clients are paying for mental health services out-of-pocket. The participant groups were further separated into quarters. Half of the group of participants who received surveys indicating that all of the clients are paying for services via managed care were given the DMS-IV criteria for disorders/symptoms presented by the individuals in the vignettes, and the other half of the group were not given the

diagnostic criteria. The participants in the out-of-pocket group were divided in the same fashion, where half received the DSM-IV diagnostic criteria, and the other half did not.

Participants were randomly assigned the order in which they read the vignettes, specifically 32 forms of the survey were created to attempt to ensure that order effects would not occur. Perfect balance was not maintained for two reasons: (a) researcher error that resulted in the creation of 27 rather than 32 forms, and (b) participant omission of responses to items. Although a small imbalance occurred there was no substantial violation in randomization, notably the four forms were returned in the following proportion: 40.00% DSM-criteria provided, 60.00% DSM-criteria not provided, 50.00% out-of-pocket, and 50.00% managed care.

After each vignette, participants were asked about the diagnostic decisions they would make regarding each client. Participants were specifically asked: (a) if they would assign the client a DSM-IV diagnosis? (b) If 'yes', what diagnosis would be assigned? (c) If 'yes' to the first question, why would the diagnosis be assigned? (d) How important it is for this client to receive treatment? and (e) What are the reasons to classify clients if their symptoms do not meet diagnostic criteria?

Explanation of narcissism, empathy, and motivated reasoning assessment. Studies have shown that unethical behaviors are related to personality characteristics associated with low emotional intelligence (Meser-Magnus et al., 2010), high narcissism, and low empathy (Brown et al., 2010; Monro et al., 2005). The study explored the personality characteristics associated with making unethical diagnostic decisions related to managed care. As indicated by previous research, it was hypothesized that unethical

behaviors would be associated with high narcissism and low empathy (Brown et al., 2010; Monro et al., 2005). The researcher believes that this is the first study of its kind.

Participants were mental health practitioners, and it is possible that they were familiar with the standard measures used in the study. This was an anticipated, but unavoidable, limitation of the study. Because research results have more validity when standard measures were used, I used them rather than using only non-standard instruments. I did, however, use one of the standard measures (i.e., the Counseling Self-Estimate Inventory) in a non-standard way, which could compromise the measure's validity.

Measure of narcissism. I measured narcissism using a subset of Larson et al. (1992) Counseling Self-Estimate Inventory (COSE), which is a measure of counselors' judgment of their professional capabilities. The COSE is a brief self report inventory. Items encompass a range of psychological professional skills, including but not limited to (a) responding to clients, (b) assessment, (c) crisis invention, and (d) case conceptualization. Participants in the current study responded to 20 scale items on a five-point Likert scale (Larson et al., 1992).

Larsen, Suuki, Gillespie, Potenza, Bechtel, and Toulouse (1992) developed the COSE across five studies. The internal consistency reliability estimate of the COSE scores was $r = .93$, $p < .05$, suggesting that it is a sound measure of self-reported professional skills. Individual items produced a wide distribution of internal correlations, suggesting that the COSE does not capture the multidimensional and minute characteristics of self-reported therapeutic skills. This was not an issue with regard to the current study, because the assessment of specific dimensions of specific counseling skills

extends beyond the scope of the dissertation. The test-retest reliability of the COSE is r = .87, $p < .05$ (Larson, et al., 1992). Additional studies have reported acceptable levels of internal consistency (.90) for the overall scale (Israelashvili & Socher, 2007).

This study used the COSE as opposed to other measures, for several reasons. Initially the researcher planed to use Raskin and Hall's (1979) shortened form of the Narcissistic Personality Inventory (NPI-40), which is a general measure of narcissism, and considered the *gold standard* measure to assess global narcissism in research. However, this and other measures were deemed inappropriate for several reasons. During the proposal for this dissertation the committee recommended that narcissism be conceptualized using an inventory that was directly related to mental health practitioner skills. The narcissistic scale of the MCMI is most frequently used with clinical populations, which are not comparable to the participant sample in this study. Other measures closely examine sub-components of narcissism, such as entitlement, which would limit the present findings (Pryor, Miller, & Gaughan, 2008). Although COSE is not intended to measure narcissism the researcher and supervisory committee hypothesized that participants with high levels of narcissism would demonstrate extremely elevated scores on the COSE. Some of the dissertation committee members had experiences with clinicians who only admit to superior clinical skills, suggesting a high level of narcissism.

In the current study, 84 participants completed the COSE items, and there were no issues with missingness; the COSE's reliability coefficient is r = .37. The low reliability suggests that participants recognized the measure as one from their own professional repertoire, and responded with a high level of social desirability. Although the measure

was unusable for its original intended purpose, it did highlight the possibly high level of participant social desirability, which is presented in the discussion chapter of this dissertation.

Measure of empathy. I used a modified version of Spreng, McKinnon, Mar, and Levine's (2009) Toronto Empathy Questionnaire (TEQ) to measure empathy. The TEQ is a brief self-report measure of empathy. Items encompass a range of empathy-related attributes. Participants respond to the 16 scale items on a four-point Likert scale (Spreng et al., 2009). To attempt to relate the questionnaire items with the practitioners' professional empathy, the items were altered slightly. For example, this item, "When someone is feeling excited, I tend to get excited too." (Spreng et al., 2009, p. 71) was edited to say, "When a client is feeling excited, I tend to get excited too."

Spreng and colleagues (2009) constructed the TEQ using exploratory factor analysis statistical methods. The researchers developed this brief scale to assess *general empathy* using common concepts among empathy definitions and published assessments. The TEQ is a 16-item self-report measure that encompasses a range of empathy related attributes. The TEQ has high internal consistency (.87) and high test-retest reliability, r = .81, p< .001. The TEQ retest was conducted a mean of 66.1 days (SD = .635, range 57-84) following participants' initial participation. Additionally, all of the items of the TEQ assess the same construct, as all of the items demonstrate sound item-remainder coefficients, ranging from .31-.71 (Spreng et al., 2009).

This study used the TEQ, as opposed to other measures, because it is an efficient self-report tool to assess general empathy. Other standard empathy measures have questionable psychometric characteristics, assess components of empathy but not the

gestalt of empathy, and/or target specific populations. The Empathy Scale (Hogan, 1969) has low internal consistency and test-retest reliability. Additionally, the Empathy Scale appears to be a more valid measure of social skills, instead of empathy (Spreng et al., 2009). The Questionnaire of Emotional Empathy (QMEE; Mehrabian & Epstien, 1972) was originally intended to examine emotional empathy. However Mehrabian et al. (1988) reported that the scale is a more accurate assessment of individuals' emotional *arousability* as opposed to general empathy (Mehrabian et al., 1988). Several empathy scales that were inappropriate for use in the proposed study were designed for evaluation within specific populations. Since the participants in this study were all mental health practitioners, it was inappropriate to use measured normed for other professional groups, such as the Jefferson Scale of Physician Empathy (Hojat et al., 2001), the Nursing Empathy Scale (Reynolds, 2000), and the Autism Quotient (Baron-Cohen, Wheelright, Skinner, Marin, & Clubley, 2010). For all the above reasons, these measures, as well as other similar measures, were inappropriate for use in this study.

In the current study, 90 participants completed the TEQ items, and there were no issues with missingness; the TEQ's reliability coefficient is $r = .12$. The low reliability suggests that participants recognized the measure as one from their own professional repertoire, and responded with a high level of social desirability. As previously mentioned the TEQ items are presented with four-point Likert responses, and on almost all items participant responses reached a statistical ceiling. Although the measure was unusable for its intended purpose, it did highlight possibly high levels of participant social desirability, which is presented in the discussion chapter of this dissertation.

Motivated reasoning and cognitive schemas. Participants were asked to comment on two scenarios that describe unethical behavior. The first scenario described a situation that is *generally unethical*, stealing a tangible item from a grocery store. The second scenario described a situation that is *professionally unethical*, changing dates on an insurance form. Following each scenario a forced choice item asked participants if the behavior described is ethical or unethical. As explained in the literature review for this dissertation when individuals are motivated to reduce dissonance between beliefs and behaviors, they will adopt attitudes that are aligned with the endorsement of negating constructs. Individuals will come to the conclusions that they *want to reach* because they are personally *motivated* to do so (Aronson & Reilly, 2006).

In the current study, 90 participants completed the motivated reasoning items, and there were no issues with missingness. However the items were highly transparent to the participants, therefore it was impossible to evaluate participant motivated reasoning. Specifically 93.41 % of the participants reported that first motivated reasoning item was unethical, and 92.22% of the participants reported that the second motivated reasoning item was unethical. Although the two items were not unusable for their original purpose, they further highlight levels high participant social desirability, which is presented in the discussion chapter of this dissertation.

Procedure

First, I sought approval for the study from the Institutional Review Board (IRB) of the City University of New York Graduate School and University Center. Once IRB approval was given I sought out psychologists in private practice to participate in this study. Specifically, I gained approval from the APA to email the members of Divisions

12, and 29. The study was conducted as an online study, and participants completed the research questionnaire online using the City University of New York Graduate School and University Center survey service.

The survey took participants about 25 minutes to complete. At the end of the survey participants were given the option to enter into an American Express gift card lottery. The lottery offered participants a chance to win one of three $25 American Express gift cards. To ensure participant confidentiality, individuals who entered the lottery were instructed to enter their email addresses into a website link that was not associated with the questionnaire. Participant email addresses entered into the gift certificate lottery were not connected in any way to survey responses. Participant responses were downloaded from the survey website onto a spreadsheet. The data were transferred from the spreadsheet to other statistical software for statistical analysis.

Data Analysis

The study used a repeated measures design for the vignettes. Participants accessed and provided data for questionnaires according to a 2x2 format (managed care and out-of-pocket crossed with DSM provided and not provided) and 4 within groups (the four different vignettes, gray male, gray female, diagnosis, and no diagnosis). To test the hypotheses and analyze the data from this study various statistical methods were employed. Descriptive statistics were used to tabulate the demographic variables including personal, educational, and professional information and compile responses about participants' sex, age degree, area of specialization, number of years since a course/workshop focusing on professional ethics and law, years in private practice, type of practice, participation in managed care plans, percentage of clients who pay via

managed care plans, and theoretical orientations. Descriptive statistics were also used for participants' responses about their perception of the importance of and adherence to professional ethical standards, diagnostic decisions related to managed care clients, and motivated reasoning. Following the format of the pilot study, data were examined using cross tabulation, frequency counts, and chi-square analysis. These methods were used to examine participants' responses about their perceptions of self and actual behavior.

Logistic regression was used to test hypotheses and examine possible relationships between and among the independent variables. Dependent variables are the participants' responses about perception-of-self and actual behavior. Independent variables are the demographic information, importance of adherence to ethical standards, importance of ethical standards, empathy, and narcissism characteristics. Stata 12 (StataCorp, (2011) was used to perform all of the analyses shown here.

Chapter IV

Results

The aim of this research was to further examine managed care's relationship to practitioners' diagnostic decisions, professional ethics, and personal characteristics. This chapter reports descriptive statistics and results for the hypotheses of this research.

Descriptive Statistics of Survey Completion

Table 10 reports how many participants completed the survey, and each of the four types of the survey.

Table 10

Participant Completion of the Four Forms of the Survey

Form	*N*	%
DSM-IV Criteria Provided/ Managed Care	22	21.78
DSM-IV Criteria Not Provided/ Managed Care	28	27.72
DSM-IV Criteria Provided/ Out-of-Pocket	30	29.70
DSM-IV Criteria Not Provided/ Out-of-Pocket	31	30.69

Note. N = 101

Descriptive Statistics of Reported Data about DSM-IV and Diagnostic Training

Participants responded to a question that specifically asked about the last time that they had participated in a course/workshop that focused on the DSM-IV and diagnostic

training. Table 11 shows that 60 participants (62.50%) reported that they have taken a diagnostic class within the last 5 years. There are, however, zero continuing education courses on the APA website that focus on this topic (APA, 2012); so participants must have received training from another source.

Table 11

Years since Completion of a Course/Workshop Focused on the DSM-IV and Diagnostic Training

Time Since Course Completion	*N*	%
Within the last year	16	16.67
Within the last 1-5 years	44	45.83
6-10 years ago	24	25.00
More than 10 years ago	12	12.50

Note. $N = 96$

Descriptive Statistics of Reported Data about APA's Ethics Code

Participants responded to several questions about their familiarity with, subscription to, and judgment of the importance of the APA ethics code; participant responses to these items are presented in Table 12.

Table 12

Descriptive Statistics Reported about the APA Ethics Code

		N	%
Familiarity with Ethics Code			

	Extremely	43	44.33
	Moderately	46	47.42
	Somewhat	8	8.25
Time Since Course Completion			
	Within the last year	28	28.87
	Within the last 1-5 years	47	48.45
	6-10 years ago	11	11.34
	More than 10 years ago	11	11.34
Agreement with Ethics Code			
	All of the Time	19	19.59
	Often	70	72.16
	Sometimes	8	8.25
Adherence to Ethics Code			
	All of the Time	58	59.79
	Often	35	36.08
	Sometimes	4	4.12

Importance of Adherence			
	Very Important	65	67.01
	Important	25	25.77
	Moderately Important	0	0
	Of Little Importance	7	7.22
	Unimportant	0	0

Note. N = 97

The vast majority of practitioners who responded to the items (*n* = 97). Participants who responded reported that they are at least moderately familiar with the ethics code (*n* = 89, 91.75%), and completed a course or workshop about the ethics code within the past 5 years (*n* = 75 of 97, 77.32%).

What is interesting about such a high percentage (77.32%) of participants who report that they have completed a course or workshop within the last five years is that out of all of the continuing education classes offered on the APA website, only one focuses on the ethics code (APA, 2012). This means that participants attended courses or workshops from other sources (e.g., colleges/universities, convention presentations, workshops unaffiliated with APA).

From the next three sections of Table 12, we are able to see the participants' reports about their agreement with, adherence to, and importance of adherence to the APA ethics code. Specifically, of the 97 participants who responded to the item, the majority (*n* = 89,

91.75%) indicated that they agree with the APA ethics code either all of the time or often. A similar high percentage of those responding (95.87%, *n* = 93 out of 97) stated that they always or often adhere to the ethics code, and the vast majority of those responding (*n* = 90 out of 97, 92.78%) viewed adherence to the ethics code as very important or important.

Three cross tabulations examined the data from the data previously reported in the table (Table 12): adherence, importance of adherence, and agreement with APA ethics code. When participants' responses about their adherence and agreement with the APA ethics codes were tabulated, the most frequent joint distributions found were for individuals who reported that they (a) often agree with the APA ethics code and adhere to it all of the time (*n* = 41), and (b) often agree with the APA ethics code and often adhere to it (*n* = 28).

When participants' responses about their adherence and the importance of their adherence to the APA ethics codes were tabulated, the most frequent joint distributions found were for individuals who reported that they (a) adhere to the APA ethics code all of the time and consider this adherence very important (*n* = 45), and (b) often adhere to the APA ethics code and consider this adherence very important (*n* = 19).

The third cross tabulation examined participants' responses about their agreement with the APA ethics code and the importance of their adherence to the APA ethics code. The most frequent joint distributions found were for individuals who reported that they concurrently (a) often agree with the APA ethics code and consider their adherence to the code very important (*n* = 45), and (b) often agree with the APA ethics code and consider their adherence to the APA ethics code important (*n* = 23).

Formal statistical tests of the relationships between adherence and agreement, adherence and importance, and agreement and importance are informative. Marginal homogeneity (Agresti, 2007) tests whether dependent table margins. The marginal homogeneity test between adherence and agreement shows that (χ^2 (2) = 40.02, p < 0.001). This lack of homogeneity is created by the relatively large number of respondents who reported always adhering to (n = 45) vs. the relatively small number who reported always agreeing (n = 4) with the ethics code. The second test of marginal homogeneity between agreement and importance shows that (χ^2 (2) = 57.07, p < 0.001). This second lack of homogeneity is created by the relatively large number of respondents who report that adherence is very important (n = 45) vs. the small number who report always agreeing (n = 1) with the ethics code. The third test of marginal homogeneity, between adherence and importance, (χ^2 (2) = 3.81, p = .15), is created by the relatively large number of respondents who report always adhering to the ethics code (n = 45) vs. the relatively small number who report very important (n = 45).

The three joint distributions highlight a high level of participant socially desirable responding, which is discussed in the next chapter.

Relationship Between Participants' Ethical Beliefs and Self-Reported Behavior and Their Beliefs about Classifying Clients Who Do Not Meet DSM Criteria

Participants were asked, "Is there ever a reason to classify someone who seeks your services but whose symptoms do not meet criteria for a DSM-IV diagnosis?" of the 95 participants who answered the question, 58 (61.05%) reported "yes".

Further five cross tabulations were conducted to consider the participants' responses to the previous question, and their responses about their (a) familiarity, (b) adherence to, and (c) agreement with the APA ethics code, as well as (d) the level of importance they attach to adherence to the APA ethics code, and (e) time elapsed since their last APA ethics class/workshop. For all five of the cross tabulations an interesting and similar pattern emerged. The most frequent combination of responses in the first cross tabulation (familiarity with code and false diagnosis of a client) was reported by 27 participants, who indicated that they are moderately familiar with the APA ethics code but would concurrently falsely diagnose a client. In the second cross tabulation (adherence to ethics code and false diagnosis of a client) the most frequent combination of responses was reported by 29 participants, who indicated that they abide by the APA ethics code without fail but would concurrently falsely diagnose a client.

Results of the third cross tabulation (importance of adherence to ethics code and false diagnosis of a client) indicated that the combination responses most frequently reported was by 38 participants who feel that it is very important to adhere to the APA ethics code but would concurrently falsely diagnose a client. The most frequent joint response from the fourth cross tabulation was reported by 38 participants who indicated that they often agree with the APA ethics code, and would incorrectly diagnose a client.

The fifth cross tabulation (years since completion of ethics course and false diagnosis of a client) found that 29 participants completed ethics training in the last 1- 5 years, but would diagnose a client who demonstrated symptoms that did not meet DSM-IV criteria. The five findings are of crucial interest to the current work specifically because adherence to the code requires both competence in one's professional technique and honest behavior. Diagnosing clients who do not meet diagnostic criteria with a diagnostic category is neither competent nor ethical (Racanello, 2010).

Participants' Responses to the Fictional Clients Presented in the Vignettes

Participants were presented with four vignettes about fictional clients. After each vignette participants were asked about the diagnostic decisions they made regarding each client; specifically they were asked: (a) If they would assign the client a DSM-IV diagnosis? (b) If 'yes', what diagnosis would be assigned? (c) If 'yes' to the first question, why would the diagnosis be assigned? and (d) How important it is for this client to receive treatment? The data for each of these questions is depicted in Tables 13, 14, 15, and 16.

Table 13

Participants' Decisions to Diagnose Each of the Fictional Clients

	Decision to Diagnose, *N*		% (diagnose)
Client	No	Yes	
Subthreshold Male	31	47	60.26
Subthreshold Female	26	50	65.79
Meets DSM-IV Diagnostic Criteria	19	51	72.86
Does Not Meet DSM-IV Criteria	29	41	58.57

Table 13 shows that participants were more likely to diagnose the fictional clients when they presented with a higher number of symptoms, specifically the client with the highest number of symptoms was diagnosed 72.86% of the time while the other three fictional clients were diagnosed less frequently. What is interesting, however, is that the other three fictional clients did not meet DSM-IV diagnostic criteria but were all diagnosed at least 58.57% of the time.

Client misdiagnosis was an anticipated result of this work, however it was unclear why participants would misdiagnose individuals who did not meet diagnostic criteria. Thus, participants who diagnosed the fictional clients were asked to indicate why they assigned a diagnosis (see Table 14).

Table 14

Reason to Diagnose Fictional Client

Client	Reason to Diagnose	*N*	%
Subthreshold Male	Client Meets Criterion	32	76.19
	Client would Benefit from Services	6	14.29
	Practitioner Reimbursement	4	9.52
Subthreshold Female	Client Meets Criterion	34	73.34
	Client would Benefit from Services	8	17.02
	Practitioner Reimbursement	5	10.64
Meets DSM-IV Criteria	Client Meets Criterion	40	80.00
	Client would Benefit from Services	7	14.00
	Practitioner Reimbursement	3	6.00
Does Not Meet DSM-IV Criteria	Client Meets Criterion	23	62.16
	Client would Benefit from Services	10	27.03
	Practitioner Reimbursement	4	10.81

Table 14 shows that for all four fictional clients, the participants most frequently reported that their reason to diagnose was because the client met DSM-IV criterion, followed by the client would benefit from therapeutic services, followed by practitioner reimbursement for the mental health services rendered. As previously indicated only one of the four fictional clients actually met DSM-IV diagnostic criteria, however the majority of the participants thought that all four of the clients demonstrated symptoms

which met diagnostic criteria. To explore this finding further, the correlation between misdiagnosis and time elapsed since participants took a class that focused on diagnosis and the DMS-IV was examined; however no significant relationships were found. Specifically, the Kendall's tau-b correlation between the time elapsed since last ethics training and assignment of unmerited diagnoses assigned to fictional clients were Gray Male, Gray Female and non-diagnosis vignettes were -.10 (n = 77, p = .35), -.14 (n = 75, p = .20) and .063 (n = 69, p = .58), respectively. All are non-significant.

To further understand why participants may incorrectly diagnose clients, the survey asked respondents to indicate how important treatment was for each fictional client (see Table 15).

Table 15

Treatment Level of Importance

Client	Level of Importance	*N*	%
Subthreshold Male	Somewhat Important	6	14.29
	Very Important	4	9.52
	Essential	32	76.19
Subthreshold Female	Somewhat Important	8	17.02
	Very Important	5	10.64
	Essential	34	72.34
Meets DSM-IV Criteria	Somewhat Important	7	14.00
	Very Important	3	6.00
	Essential	34	80.00
Does Not Meet DSM-IV Criteria	Somewhat Important	7	27.03
	Very Important	3	10.81
	Essential	40	62.16

Table 15 shows that for all four fictional clients, the participants most frequently reported that it was “essential” that the client to receive psychological services.

Participants were more apt (80.00%) to indicate "essential" for the client who met diagnostic criteria compared to the client (62.16%) who presented with only one symptom.

Participants who diagnosed the fictional clients were asked to indicate what specific diagnoses they would assign. Table 16 reports the five most frequently reported diagnostic assignments for each of the four clients.

Table 16

Five Most Common Diagnoses Assigned to the Fictional Clients

Client	Diagnosis	*N*	%
Subthreshold Male	Attention Deficit Hyperactivity Disorder (ADHD)	28	
	Two or More Diagnoses	5	
	Mood Disorder, including Anxiety and Bipolar disorders	5	
	Adjustment Disorder	1	
	Axis I Diagnosis Deferred, 799.99	1	
Subthrehold Female	Anxiety Disorder, including Anxiety NOS, Generalized Anxiety, and Panic disorders	24	
	Depressive Disorder	7	
	Two or More Diagnoses	6	
	Adjustment Disorder	6	
	Mood Disoder, NOS	4	
Meets DSM-IV Criteria	Oppositional Defiant Disorder	15	
	Two or More Diagnoses	12	
	Impulse Control	9	

	Disorder, including but not limited to Intermittent Explosive and Impulse Control, NOS disorders		
	Conduct Disorder	9	
	Mood Disorder, including Mood NOS and Anxiety disorders	3	
Does Not Meet DSM-IV Criteria	Anxiety Disorders, including but not limited to Generalized Anxiety, Separation Anxiety, and Panic disorders	13	
	Depressive Disorders	8	
	Two or More Diagnoses	5	
	Mood Disorder, NOS	3	
	Adjustment Disorder	2	

In addition to the five most frequent diagnoses assigned, participant diagnostic free responses were further categorized into 3 broad themes. Participants reported diagnostic assignments which were related to the symptoms with which the fictional client presented. For all four clients, some participants reported that they needed more information to assign a diagnosis. Of these participants presented three sub-themes: (1) requests for additional information only; (2) requests for specific types of additional information: medical history, cognitive conditions, age; and (3) requests for additional information and one or more diagnostic assignments. For all four clients, some participants reported the same diagnosis, including but not limited to: 799.99 Axis I diagnosis deferred; Mood Disorder, NOS; and Adjustment Disorder.

Regression Model

The chi-square test for the full model compared to the design only model has (χ^2 (5) = 23.61, p <.001); thus we prefer the full model compared to the design model (Appendix F). The intra-class correlation (ICC) (ICC = 0.39) for the full model is the lowest compared to the same correlations for the null (ICC = 0.53) and design (ICC = 0.55) regression models. The decreased ICC for the full model compared to the other two models makes sense because respondent level characteristics were added to the model; the addition of these variables explains the participant heterogeneity.

The full regression model for this research has several interesting findings. All effects sizes for this model are reported as Cohen's *d*'s. First the full regression model's intercept is consistent with the descriptive statistics from this work. The positive intercept (.47, 95% CI = [.17, .78], p <.001) indicates that participants demonstrated a bias toward diagnosing the fictional clients. Second the vignette variables acted consistently in the regression model as they did in the descriptive statistics; participants demonstrated a greater propensity to diagnose clients who presented with a higher number of symptoms. Among the three variables associated with the vignettes, DSM-IV criteria provided and payment type, only one demonstrated an effect in the model. When participants were provided with DSM-IV criteria they were less likely to diagnose the fictional clients (.50, 95% CI = [.02, .98], p = .04).

The variables in the model which demonstrated the most considerable effects were the characteristics particular to the participants. Third, female participants were related to more frequently assigning fictional clients with diagnoses; the model reported a small effect for this variable (.33, 95% CI = [.02, .63], p = .04). Fourth, respondents who

reported that there are reasons to assign diagnoses to clients who do not meet DSM-IV criteria were associated with more frequently assigning fictional clients with diagnoses; the effect size for this variable was large (.68, 95% CI = [.37, 1.00], p <.001). Fifth participants who reported unwavering adherence to the ethics code were associated with more frequent diagnostic assignment; the effect for this variable was small (.34, 95% CI = [.05, .64] p = .02). Sixth participants who reported that it was important to adhere to the ethics code were associated with less frequent diagnostic assignment; the effect for this variable is small (-.32, 95% CI = [-.64, .00], p =.05)

Summary of Finding Related to the Hypotheses

Table 17 reports the hypotheses from this research, and indicates that two were supported, and three were not supported. I tested H01 using a probit regression model (Appendix F) that evaluated the diagnoses of clients who presented with subthrehold symptoms as the dependent variable, and included participants' gender, response about their willingness to diagnose a client who does not present with symptoms that meet diagnostic criteria, and adherence to, importance of adherence, and agreement with the APA ethics code.

I tested H02 using frequency count of participants who indicated that they reason they assigned a DSM-IV diagnosis to a client was to be reimbursed by managed care. The frequencies for this response for all four vignettes were consistently lower than those for other reasons given for diagnosing clients; hence this hypothesis was not supported. Participants possibly answered this item in this fashion due to social desirability, and/or motivated reason to believe that the presenting clients truly did meet diagnostic criteria.

I tested H03 using a regression model (Appendix F) that evaluated the diagnoses of clients who presented with subthrehold as the dependent variable, and included participants' gender, response about their willingness to diagnose a client who does not present with symptoms that meet diagnostic criteria, and adherence to, importance of adherence, and agreement with the APA ethics code. Individuals reported adherence to the ethics code was found to be statistically significantly related to their assignments of unmerited diagnoses, thus this hypothesis was supported.

H04 was not tested because the standard measures, NPI and TEQ, were transparent to the participants. H05 was not tested because the motivated reasoning items were also transparent to the participants, thus it is possible that the participants function with motivated reasoning with regard to managed care and diagnostic decisions but the items employed were not sensitive enough to detect it.

Table 17

Overview of the Hypotheses

HO Number	Hypothesis	Supported/ Not Supported
HO1	A substantial number of the clinicians will assign a DSM-IV diagnosis to the clients paying via managed-care even when they present with sub-threshold symptoms	Supported
HO2	A substantial number of practitioners will assign a faulty diagnosis to be reimbursed by third party providers	Not Supported
HO3	Within the group of practitioners who assign unmerited DSM-IV diagnoses, a significant number of practitioners will report that the are ethical 100 percent of the time	Supported
HO4	Practitioners who assign unmerited DSM-IV diagnoses, will have higher levels of narcissism and lower levels of empathy than practitioners who do not assign unmerited diagnoses	Not Tested
HO5	Significantly more practitioners who assign unmerited DSM-IV diagnoses that practitioners who do not will state that the individual in the reasoning scenario who acts unethically in a managed care situation acted ethically	Not Tested

Additional Analyses

Several additional analyses were of high interest to this research, specifically the relationship between practitioner assignments of unmerited diagnoses and their (1) responses about assigning such diagnoses, and (2) percentage of actual managed care clients. The regression model (Appendix F) previously mentioned indicated that practitioners' assignment of unmerited diagnoses was significantly related to their responses to the question, "Is there ever a reason to classify someone who seeks your services but whose symptoms do not meet criteria with a DSM-IV diagnosis?", $\beta = .69$, $z = 4.26$, and $z = .00$ $p < .001$. Further a second regression model previously mentioned indicated that practitioners' assignment of unmerited diagnoses was significantly related to their responses to the questions (1) "Do you accept managed care?", and (2) "If yes

what percentage of your practices pays via managed care", $\beta = .63$, $z = 2.30$, and $z = .021$ $p < .05$.

Chapter V

Discussion

This chapter presents key findings from the research, limitations of the current work, directions for future research, and implications for practice.

Key Findings

Although the vignettes were not sensitive enough to allow examination of practitioner differences, diagnostic assignment, and managed care, participants' responses to questions about their beliefs and practices proved informative in this regard. Participants' reports that 50% or more of their clients paid for services via managed care were associated with their affirmations that there are reasons to assign unmerited diagnoses to clients. Thus, the current research substantiates the work of others (Kielbasa et al., 2004; Lowe et al., 2007; Pomerantz & Segrist, 2006; Racanello, 2010) who also found positive relationships between assignments of diagnoses, even when not merited, and clients' method of payment. This finding suggests that practitioners believe that there are circumstances under which it is acceptable to bend the rules.

Koocher and Keith-Spiegel (2008), both of whom are experienced members of ethics boards, report that psychologists who behave unethically frequently rationalize their behavior. Indeed, the present study found a positive association between likelihood of assigning unmerited diagnoses and the belief that there are reasons to assign unmerited DSM diagnoses. Perhaps practitioners believe that it is acceptable to misdiagnose in order to provide clients with the help they need. It is also possible that some participants engage in self-deception to receive payment for there services (Tenbrunsel & Messick, 2004). According to Koocher and Keith-Spiegel, "self-deception allows one to engage in

an ‘internal con game’ to act out of self interest while believing that one has acted morally” (p. 15).

Current results and those from the pilot study (Racanello, 2010) demonstrate that some practitioners report that they always act ethically, but concurrently practice and report unethical clinical behaviors (i.e., assignment of unmerited diagnoses). Thus, there is a disparity between psychologists’ self-beliefs that they are ethical and their demonstrations of unethical behavior. However, the current research was not able to examine reasons for this disparity further by looking at possible associations between unethical behavior and participants’ responses to questions regarding empathy, narcissism, and motivated reasoning. Responses to the items that assessed these characteristics were unusable because of socially desirable responding by participants.

Because they are trained in diagnosis, I expected that practitioners would respond to the vignettes with similar diagnoses. However, decisions about diagnosis varied substantially among practitioners. Indeed, a notable finding was the statistically significant individual differences among practitioners’ diagnostic assignments. Koocher and Keith-Spiegel (2008) list incompetence among their reasons for clinicians’ unethical behaviors, and this may be true of some participants. Interestingly, many participants concurrently indicated that they had attended a diagnostic workshop/course within the last five years, assigned unmerited diagnoses, and reported that the fictional client presented with symptoms which met diagnostic criteria. Also, participants who were given diagnostic criteria in their questionnaires were less likely to diagnose than were participants who had to make diagnostic judgments without benefit of a listing of criteria. This suggests that practitioners should consult the DSM directly before making

diagnoses. Being female was also more frequently associated with assignment of unmerited diagnoses, and the reason for this is unclear.

One concern when designing self-report surveys is that the scales may be influenced by social desirability bias (SDB). SDB occurs when participants respond to items in a distorted manner, specifically in a direction considered desirable by society (Leite & Cooper, 2010). The participants in the current research demonstrated a high propensity toward SDB that is suggested by the high percentage of participants who reported (a) unwavering adherence to the APA ethics code, (b) recent participation in ethics and diagnostic courses, (c) response patterns that met ceiling criteria on the standard scales and reasoning scenarios, (d) that clients' presenting symptoms met diagnostic criteria, and (5) that clients had an intense need for mental health services. It is possible that the participants were unaware of their biases and that they did not intend to report deceptive answers. In fact they may have believed that what they reported about themselves was true.

Limitations and Suggestions for Future Research

The results of this study have several substantial limitations, which reduce the generalizability of the findings. The number of participants was low, thus all results should be considered with caution. In addition, only a small percentage of those solicited responded. Participants were solicited through online methods only, thus the participant sample was limited to individuals who are comfortable using the internet and responding to online surveys.

The vignettes were written with the intent of being as realistic as possible, but did not provide the same amount of information that most practitioners obtain from *real*

clients. The length of the survey was too long and possibly discouraged participants from completing the questionnaire. The length also possibly discouraged potential participants from participating in the research at all. Participants seemed to respond as per their own clinical practice and clients, as opposed to using the client information presented. Specifically, it seemed that the participants did not fully take into account the material provided by the researcher, and instead considered the fictional clients as if the individual presented in their *real life* clinical practice setting. This response pattern seems to be the case, because participants demonstrated statistically high levels of individual differences. One example is that participants who treat high levels of clients who pay via managed care assigned out-of-pocket fictional clients with unmerited DSM-IV diagnoses. Participants may have been more likely to respond to the study materials as the material was intended if they were cognitively primed to think about managed care issues immediately before the vignettes were presented. Results may have also benefitted from asking it the participants were specifically asked about how they felt about managed care and what was the impact that third party providers had on their professional practice.

Additionally, the survey, especially the standard measures and the motivated reasoning questions, were transparent to the participants. They appeared to respond to these items in a socially desirable manner, and their responses were unusable for statistical analyses. Because respondents were mental health professionals who are familiar with questions about personal characteristics, it was difficult to find questions that would measure empathy, narcissism, and motivated reasoning in a non-transparent way. The study might have benefited from administration of a scale to detect socially desirable responding. Further, if the standard measures were usable the study might have

benefited from examining the relationship between the standard measures and rule following behaviors.

One limitation of the pilot for this dissertation was that it did not ask participants to indicate their knowledge of the DSM-IV. Thus, when participants indicated that they would diagnose clients because the clients' symptoms met diagnostic criteria, it was unclear if they were doing so specifically because of managed care reasons, and/or because they: (a) were not familiar enough with diagnostic criteria to correctly assign a diagnosis, and/or (b) had different reason(s) for providing diagnoses. Thus, the current study queried participants (a) about the last time they participated in a class/workshop which focused on managed care, and (b) why they would assign a client with a diagnosis. The queries, however, did not clarify participants' knowledge of DSM-IV criteria. Future research should address each of the limitations described.

Albeit these and other limitations, the results of the study add to the evidence that individuals who present with very few symptoms may be diagnosed by a practitioner for the purpose of managed care. Findings from this research lead to several interesting follow-up suggestions. First, the relationship between managed care and practitioners diagnostic decisions continues to need clarification. Thus, future research should build on this work as well as that of Kielbasa et al. (2004), Pomerantz and Segrist (2006), Lowe et al. (2007), and Racanello, (2010) to continue to study this relationship. Future research may be able to discern a more direct relationship between psychology and managed care if participants are specifically asked what they think of managed care.

Second, the results indicate that mental health practitioners are not consistent with regard to diagnostic assignment, although the DSM-IV provides set criteria for diagnoses.

Practitioners' individual differences with regard to their professional behavior is a largely unstudied topic, but one that is important to understand. Third, although the use of vignettes is considered a limitation of the present research, vignettes are frequently used in both low and high stakes assessment situations: surveys, comprehensive and qualifying evaluations for doctoral programs, and licensing exams. In this case, I used vignettes to evaluate individuals' diagnostic practices based on their case conceptualization of fictional clients. This is an innovative approach that provides invaluable information through the psychometric examination of such vignette-associated items.

Implications for Psychology

The current research inspired the question, "Is it ethical to follow the rules or to do what is best?." The results from this work as well as Kielbasa et al. (2004), Lowe et al. (2007), Pomerantz and Segrist (2006), Lowe et al. (2007), and Racanello, (2010) demonstrate that managed care guidelines are not requiring practitioners to do what is best for clients. Several levels of changes need to be made to enable clinicians to be reimbursed by managed care and concurrently provide their clients with treatment that is aligned with best practice.

Professional guidelines. Ethics is the area of moral philosophy which systemizes, defends, and recommends the concepts of right and wrong conduct (Cite). Professional regulations, which can be vague, contradictory, and at times unethical, are not ethics codes. Additionally professional regulations are not *ethical* simply because of the titles of the regulations include the word ethics or ethical and/or because the code includes general beneficence principles in its introduction.

Campbell's Law says, "The more any quantitative social indicator is used for social decision-making, the more subject it will be to corruption pressures and the more apt it will be to distort and corrupt the social processes it is intended to monitor. (Campbell,1975)" The APA Ethical Standards are used for social decision making, and with regard to managed care, the standards appear to have been corrupted and distorted. This study's results provide insight into the need for psychology to have a practice code that clinicians are able to refer to in their daily practice. For the regulations to be useable to clinicians, practitioners who are actively involved clinical practice should design the guidelines. Specifically, clinicians who treat clients who pay via managed care may be the best suited individuals to write professional regulations about managed care.

Diagnostic guidelines. The DSM-IV is considered the primary tool to evaluate and assign appropriate psychiatric and psychological diagnoses. Precise diagnosis is intended to inform mental health interventions: (i.e., treatment decisions, primary detection of illnesses, effective and appropriate treatments), and increaseing individuals' ability to function in their day-to-day lives. However, the DSM-IV is subject to various criticisms and has been since immediately following its publication in 1994. Some of the specific issues with DSM-IV include but are not limited to: (1) no instructions about how to assess the severity and disability of a disorder, (2) flawed multi-axial system, (3) overuse of the "Not Otherwise Specified" diagnosis, (4) high rates of comorbid diagnoses, (5) inability to detect genetic markers for diseases, and (6) lack of cross-cultural information (Kupfer, Regier, & Kulh, 2008).

As previously mentioned managed care providers require that for treatment approval, a DSM-IV diagnosis be assigned to clients.; Tthis is disconcerting for two

reasons. Managed care approves of services based on a diagnostic system that which is flawed. By the time individuals demonstrate symptoms that which qualify for a DSM-IV diagnosis, their problems may be chronic and much less responsive to treatment. A cost-benefit analysis would, I believe, show that treatment of individuals with fewer symptoms is preferable.

Implications for Practice

Managed care is a very *hot topic* in psychology. Managed care was mentioned over 30 times in professional emails that I monitored for a month, and at least 10% of those managed emails were marked as *high priority*. APA has multiple sections of its website dedicated to managed care (APA, 2012). Additionally, at the 2011 APA Annual Convention several vendor stands were dedicated solely to managed care. Specifically, these venders advertised managed care software, instructional information to support practitioners' demonstration of ethical conduct when reporting to managed care companies, and guidelines and support services meant to protect managed care whistle-blowers. The convention also featured presentations focused on managed care. In a professional development discussion, one of the leaders presented the following three fictionalized characters faced with managed care ethical dilemmas. All three characters' stories present multifaceted dilemmas related to managed care and mental health.

The first individual is a managed care specialist for a hospital inpatient psychiatric unit. Throughout his career, he has been frustrated when managed care companies do not approve additional inpatient care, especially when the patients present with symptoms which make them a danger to themselves and others. Unwilling to make concessions that endanger the lives of individuals, he reports incorrect information to managed care

companies, specifically he: (a) alters dates, medications (including dosing information), and diagnostic codes; (b) reports incorrect information about the occupancy level of inpatient unit and re-admissions into group-home; (c) withholds information from psychiatric notes and medical test results; and (d) asks medical students to conduct patient assessments, so he can subsequently report that the assessments were incorrect because medical students conducted them.

The second fictional character is a doctoral level psychologist with a booming private practice; he has so many clients that he should refer some clients to a different practitioner. He is frustrated with the managed care guidelines that make it nearly impossible for some individuals to receive treatment. He knows from previous experience that if he refers the clients to other practitioners, they will not accept the clients' managed care plans, because the practitioners do not want to deal with the hassles of managed care. Although he does not need to see additional clients, he carves out time to see these clients (i.e., those he should refer) himself. To be reimburse by the clients' managed care plans he often needs to (a) report incorrect appointment dates, (b) up-code or down-code clients' diagnoses, (c) state that he is treating individuals when he is treating couples and families, and/or (d) maintain that he is treating one sibling, when he is seeing another. At times the psychologist does not file the managed care forms because it is *not worth it*. The time and costs of office supplies needed to complete the managed care forms exceed the reimbursements that he would receive for the services rendered.

The third fictional character is a mental health practitioner who is just starting to see clients in a private practice setting. She is frustrated that she had worked so hard to earn her degree only to be hindered when trying to grow her practice and receive

payment because of managed care policies. To enable her to receive reimbursement for her services she reports: (a) incorrect appointment dates, (b) misdiagnoses, and (c) individual treatment when seeing couples.

This study's results and anecdotal reports such as those above provide insight into the behavior of psychologists who get reimbursements through managed care. While it is important for psychologists to behave ethically, it is also important for clients to get the services they need and for psychologists to receive payment for services provided. An understanding of the complex and sometimes unethical relationship between practitioners and their managed care providers should inform training programs. Students should learn about and adhere to professional guidelines and laws relative to managed care. Additionally, information from studies such as this could be used to understand the regulations of managed care companies that are associated with unethical behaviors of practitioners. It may be time to examine the validity of managed care regulations and to determine if managed care firms need to adopt different formulas to enable practitioners to be reimbursed for the services they provide while also enabling insurance companies to turn a profit.

APPENDIX A

Information Page

My name is Amy Michael Racanello, and I am a doctoral candidate in School Psychology in the Ph.D. Program in the Educational Psychology at The Graduate Center of the City University of New York (CUNY). I am seeking participants for a research project. The aim of this work is to examine diagnostic decisions made by mental health practitioners. I am the Principal Investigator of this project, which is my dissertation.

Participation in this study involves completing a questionnaire, which takes about 20 minutes. The link to the online survey is provided at the end of this message. There are no risks to you in taking part in this study. You do not have to provide your name or any other identifying information. Participation is voluntary. You can choose not to complete the questionnaire.

If you would like a copy of the results of this study, please email me your address, and I will send you a copy in the future. In addition, if you choose to complete the study, you may submit your email address at the end of the questionnaire to be entered into a drawing to receive 1 of 3 $25 American Express gift cards. Please know that email addresses will not be tied to your questionnaire responses in any way.

If you have any questions about this study, you can contact me at aracanello@gc.cuny.edu, or either of my research advisors, Georgiana Shick Tryon, at gtryon@gc.cuny.edu; Jay Verkuilen, at jverkuilen@gc.cuny.edu. If you have questions about your rights as a participant in this study, you can contact Kay Powell, IRB Administrator, The Graduate Center, City University of New York, (212) 817-7525, kpowell@gc.cuny.edu.

Thank you in advance for your participation in the study.

APPENDIX B

Demographic Questions

1. What is your gender?

Male
Female
Other

2. What is your age?

- 25 years
25-35 years
35-45 years
45-55 years
55- 65 years
65-75 years
+75 years

3. What is your degree?

PhD
PsyD
EdD
Other

4. What was your area of specialization during your education?

Clinical Psychology
Counseling Psychology
School Psychology
Other, please specify

5. What theoretical orientation do you endorse?

Behavioral
Cognitive-Behavioral
Eclectic
Psycho-dynamic
Systems
Other, please specify

6. Are you a member of American Psychological Association (APA)?

Yes

No

7. If ‘YES’ to Question 6, do you belong to specific APA Divisions?

Yes
No

8. If ‘YES’ to Question 7, please list which APA Divisions you belong to:

9. Are you currently in private practice?
Yes
No

10. If ‘YES’, to Question 9, how many years have you been in private practice?

-5 years
5- 10 years
10-15 years
15-20 years
20-25 years
+25 years

11. Do you work primarily in private independent or group practice?

Independent
Group

12. Do you participate in managed care plans?

Yes
No

13. If ‘YES’ to Question 12, what percentage of your practice pays you for your services via managed care?

Less than 25%
25-50%
50-75%
More than 75%

APPENDIX C

Questionnaire

1. How familiar are you with the American Psychological Association's Ethics Code?

Extremely familiar
Moderately familiar
Somewhat familiar
Slightly familiar
Not at all familiar

2. How many years has it been since you took a course and/or workshop, which focused on the American Psychological Association's Ethics Code?

Within the last year
Within the last 1-5 years
6-10 years ago
More than 10 years ago

3. Please pick the answer choice which best matches your conduct with regard to the following statement: **I always adhere to the American Psychological Association's Ethics Code**.

All of the time
Often
Sometimes
Rarely
Never

4. Please pick the answer choice which best matches your conduct with regard to the following statement: **I always agree with the American Psychological Association's Ethics Code.**

All of the time
Often
Sometimes
Rarely
Never

5. How important is it to you that you adhere to the American Psychological Association's Ethics Code?

Very important

Important
Moderately important
Of little importance
Unimportant

6. How many years has it been since you took a course and/or workshop, which focused on the DSM-IV and diagnostic criteria?

Within the last year
Within the last 1-5 years
6-10 years ago
More than 10 years ago

7. Is there ever a reason to classify someone who seeks your service but whose symptoms and do not meet criteria with a DSM diagnosis?

Yes
No

Below is a list of 13 statements. Please read each statement carefully and rate how frequently you feel or act in the manner described. There are no 'right' or 'wrong' answers. There are no trick questions. Please answer each question as honestly as you can.

Never = 0 ***Rarely =1*** ***Sometimes = 2***
Often = 3 ***Always = 4***

1. When a client is feeling excited, I tend to get excited too.

2. Client's misfortunes do not disturb me a great deal.

3. It upsets me to hear that a client was treated disrespectfully.

4. I remain unaffected when a client is happy.

5. I enjoy supporting my clients.

6. I can tell when clients are sad even when they do not say anything.

7. I find that I am "in tune" with clients' moods.

8. I do not feel sympathy for clients who cause their own problems.

9. I become irritated when a client cries during a session.

10. I am not really interested in how clients feel.

11. I get a strong urge to help clients when they are upset.

12. When I hear a client is being treated unfairly I do not feel very much pity for him/her.

13. I find it silly for clients to cry out of happiness.

Use the options below to rate your ability to do the following professional tasks:

Strongly disagree = 1 ***Disagree moderately=2*** ***Neutral = 3***
Agree moderately =4 ***Strongly agree = 5***

1. My knowledge of personality development is adequate for counseling effectively.
2. My knowledge of ethical issues related to counseling is adequate for me to perform professionally.
3. My knowledge of behavior change principles is not adequate.
4. I am not able to perform psychological assessment to professional standards.
5. I am able to recognize major psychiatric conditions.
6. My knowledge regarding crisis intervention is not adequate.
7. I am able to effectively develop therapeutic relationships with clients.
8. I can effectively facilitate client self-expression.
9. I am not able to accurately identify client affect.
10. I cannot discriminate between meaningful and irrelevant client data.
11. I am not able to accurately identify my own emotional reactions to clients.
12. I am not able to conceptualize client cases to form clinical hypotheses
13. I can effectively facilitate appropriate goal development with clients.
14. I am not able to apply behavior change skills adequately.
15. I am able to keep my personal issues from negatively affecting my counseling.

A. An individual enters a local grocery store and has an impulse to steal an item or two. The person sees there is a long line at the two registers, and the manager is assisting an elderly customer carry heavy packages to her car. The person picks up an item, puts it into the pocket of his coat, and exits the store.

Was this unethical behavior?

Yes
No

B. A psychologist and a client make an appointment for a final session. After the session, the psychologist realizes that the client's insurance coverage was terminated prior to the date of the appointment. To ensure payment, the psychologist completes the managed care form with an altered date for the last session.

Was this unethical behavior?

Yes
No

Appendix D

Vignettes

Managed care and out-of-pocket vignettes only differ by one sentence: The client is paying for your services through via managed care plan/The client is paying for your services via out-of-pocket.

DSM-IV Criteria given and DSM-IV criteria not given groups will differ by one sentence: DSM-IV criteria have been provided for you to use when responding to the vignettes.

Vignette 1: Meet Criteria

A young adult male lives with his adoptive mother and grandmother in a suburb of a large metropolitan area. According to self-report he argues with her and his grandmother when he does not get his way. When with his friends he plays several intramural sports, and goes out. He reports that he has been frequently asked to leave a game due to his un-sportsman-like behaviors. Specifically he reports that he has yelled, threatened, and hit his teammates and players from other teams when angry. According to the client he is in good physical health and does not take medication.

The client has given you permission to speak to the professors in the department of his academic major. The young man's reported experiences, and observations and reports by his professors are concurrent. It seems that the client's his behavior is "quite upsetting and problematic." When questioned, neither the client nor his professors are able to indicate any recent stressor to account for the behavior. When asked if this type of problematic behavior has been an issue in the past, the client indicates that it has been problematic since he was a child. According to the client and his professors he often demonstrates aggressive behaviors, and disobeys rules. Specifically he:

- Often loses his temper even when the situation seems minor and does not call for an outburst;
- Frequently argues with others, including his family, professors, and peers;
- Will verbally attack and be aggressive toward others when upset;
- Does not follow directives;
- Will blame others when confronted about his own mistakes and misbehaviors;
- Frequently seems irritable and angry with other individuals and situations.

The client comes to see you with his mother. He reports that he thought he would be more comfortable in the consultation with his mother than by himself. When the client is in your office he sits next to his mother. When he speaks to you, he moves his legs repeatedly. He continually makes contact with his mother's legs. Using firm clear directives she asks him several times to "stop kicking her". When she asks he smiles at her and continues to move his legs. The client has come to see you because he is concerned with his problematic behavior and how it may affect his development including his academic and social progress. The client is paying for your services through via managed care plan/The client is paying for your services via out-of-pocket.

1. Would you assign this client a DSM-IV diagnosis? (Circle one)

Yes
No

2. If you answered YES to Question 1, what specific diagnosis would you assign?

3. If you answered YES to Question 1, why did you assign the diagnosis?

To be reimburse for services rendered
The client would benefit from your services
The client meets diagnostic criteria
You would gain professionally from working with this client

4. If you answered YES to Question 1, how important do you feel it is that this client received treatment?

Not Important
Somewhat Important
Very Important
Essential

Vignette 2: Does Not Meet Criteria

A young adult female lives with her biological mother and father in a suburb of a large metropolitan area. According to the client, she has a wonderful relationship with her parents, grandparents, extended family, and friends. The woman is worried because every morning she cries for 15 to 60 minutes before starting her day. She explains that once she starts her daily activities, she collects herself and participates in her activities. Further she reports that she attends bi-weekly girls' nights, and looks forward to spending time with her peers. She explains that the girls' nights alternate between her home, the homes of three peers, and an outside venue, such as a restaurant and/or local theater. According to the client she is in good physical health and does not take medication.

She explains that this crying is quite upsetting. You query the girl about possible stressors. When questioned, she is unable to indicate any recent stressor, and adds that this type of "crying behavior" has not been an issue in the past. The young woman gives

you permission to speak with her mother. According to the client's mom, her daughter is well-behaved, intelligent, and charmingly happy. The mother reports that she was a psychology major, and her daughter is one now. They are both very concerned that young woman has "some sort of anxiety problem". The client:

a. Cries for 15-60 minutes when she is getting ready to start her day.

When the client is in your office she sits attentively, speaks to you, and appears to follow the conversation. When you ask her a question she articulates her answer using well-developed expressive language skills. The woman has come to see you because she is concerned with her "morning blues" and how they may negatively impact her development including academic and social progress. The client is paying for your services through via managed care plan/The client is paying for your services via out-of-pocket.

1. Would you assign this client a DSM-IV diagnosis? (Circle one)

Yes
No

2. If you answered YES to Question 1, what specific diagnosis would you assign?

3. If you answered YES to Question 1, why did you assign the diagnosis?

To be reimburse for services rendered
The client would benefit from your services
The client meets diagnostic criteria
You would gain professionally from working with this client

4. If you answered YES to Question 1, how important do you feel it is that this client received treatment?

Not Important
Somewhat Important
Very Important
Essential

Vignette 3: Gray Criteria

A young adult male shares an apartment with his two siblings in suburb of a large metropolitan area. According to the client, he has a good relationship with his family, including his parents and siblings. He enjoys going to parties, painting, and playing the piano. According to the young man, he demonstrated well developed early literacy and fundamental math skills. He currently earns high grades. However he is concerned because he frequently has been told by professors that his lecture, lab, and discussion behaviors are "inattentive and inappropriate". According to the client he is in good physical health and does not take medication.

During the last few months he has been emailed by professors, told by his peers, and notices his own behaviors have been inappropriate and inattentive. Specifically, he has heard from peers and professors at least bi-weekly that he has "focus problems, an inability to sit still, and overall deportment troubles". When questioned he is not able to indicate any recent stressor for the behavior. When asked if this type of problematic behavior has been an issue in the past, the client reports "maybe" but is unsure. He specifically reports that he:

- Often does not pay close attention when completing assignments, such as when completing math problem sets he will add instead of subtract and vice versa, and make other careless errors;

- Will squirm in his seat and fidget, when doing sustained activities, such as in class learning, homework, watching movies, and when taking piano lessons;

- Will blurt out comments at the dinner table, when having coffee with friends, and in class when someone else is speaking, reporting that he is just too excited about what he has to say to wait for others to stop talking;

- Has gotten several emails about his inattentive and out-of line behavior in classes;

- Is easily distracted by other and external stimuli.

When in your office the client sits for the duration of the interview, but he squirms, looks around the room, and appears to have difficulty "remaining in the chair". When speaking he attends to the conversation on and off, and sometimes will interject unsolicited comments. He is concerned about the problematic behavior and how it may affect his development including his academic and social progress. <u>The client is paying for your services through via managed care plan/The client is paying for your services via out-of-pocket.</u>

1. Would you assign this client a DSM-IV diagnosis? (Circle one)

Yes
No

2. If you answered YES to Question 1, what specific diagnosis would you assign?

3. If you answered YES to Question 1, why did you assign the diagnosis?

To be reimburse for services rendered
The client would benefit from your services
The client meets diagnostic criteria
You would gain professionally from working with this client

4. If you answered YES to Question 1, how important do you feel it is that this client received treatment?

Not Important
Somewhat Important
Very Important
Essential

Vignette 4: Gray Criteria

A young adult female lives with her sister and two roommates in a house in suburb of a large metropolitan area. According to the client she has a good relationship with her family and friends. She enjoys the company of her close girl friends, whom she has known since elementary school. They shop, go to movies, and enjoying cooking "gourmet style meals." The young woman is a starter on her college's varsity soccer team, and has been cast as the comic lead in the college musical for the last two years. Although she reports positive characteristics and accolades, she explains that she frequently becomes distressed, cries so hysterically that she cannot catch her breath, and does not want to go to class in the morning. She reports that she has started to cry in classes and has needed to leave the lecture hall to collect her emotions. In the last few months, she was not able to take exams on specified exam days because she was "so hysterical and keyed-up." According to the client she is in good physical health and does not take medication.

During the last few months the client reports that she experiences crying/distress episodes almost every day, and most days at multiple times. When questioned she does not indicate any recent stressor that produced the behavior, and this type of problematic behavior has not been an issue in the past. Specifically she:

- Often is worried about school, friends, and extra-curricular activities, so much so, that she starts to cry and is unable to stop;

- Struggles paying attention in class and often loses her train of thought; she will raise her hand to answer a question, be prompted by the teacher to answer, but then is unable to answer reporting that her "mind goes blank";

- Reports being exhausted all of the time.

When the client is in your office she sits next to her mother and the two hold hands. The young woman reported that she would be more comfortable attending the consultation with her mother. Throughout the consultation, she sits quietly with tears streaming down her face. When her mother is speaking to you, the girl attends to the conversation. A few times during the conversation the client interrupts her mother respectfully to offer comments, clarify points, and explain issues/events further. When the client is queried, she speaks in a clear articulate fashion. The mother and daughter are concerned with the trouble the young woman is having, and how it may affect her development including her

academic and social progress. The client is paying for your services out-of-pocket/through her managed care plan.

1. Would you assign this client a DSM-IV diagnosis? (Circle one)

Yes
No

2. If you answered YES to Question 1, what specific diagnosis would you assign?

3. If you answered YES to Question 1, why did you assign the diagnosis?

To be reimburse for services rendered
The client would benefit from your services
The client meets diagnostic criteria
You would gain professionally from working with this client

4. If you answered YES to Question 1, how important do you feel it is that this client received treatment?

Not Important
Somewhat Important
Very Important
Essential

APPENDIX E

DSM-IV Criteria

Diagnostic criteria for Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals

(1) often bullies, threatens, or intimidates others
(2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm to others (e.g., bat, brick, broken bottle, knife, gun)
(4) has been physically cruel to people
(5) has been physically cruel to animals
(6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

Destruction of property

(8) has deliberately engaged in fire setting with the intention of causing serious damage
(9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

(10) has broken into someone else's house, building, or car
(11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
(12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

(13) often stays out at night despite parental prohibitions, beginning before age 13 years
(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
(15) is often truant from school, beginning before age 13 years

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Specify type based on age at onset:

Childhood-Onset Type: onset of at least one criterion characteristic of Conduct Disorder prior to age 10 years

Adolescent-Onset Type: absence of any criteria characteristic of Conduct Disorder prior to age 10 years

Specify severity:

Mild: few if any conduct problems in excess of those required to make the diagnosis and conduct problems cause only minor harm to others

Moderate: number of conduct problems and effect on others intermediate between "mild" and "severe"

Severe: many conduct problems in excess of those required to make the diagnosis or conduct problems cause considerable harm to others

Diagnostic criteria for Separation Anxiety Disorder

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
(1) recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
(2) persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
(3) persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
(4) persistent reluctance or refusal to go to school or elsewhere because of fear of separation
(5) persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
(6) persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
(7) repeated nightmares involving the theme of separation
(8) repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated

B. The duration of the disturbance is at least 4 weeks.

C. The onset is before age 18 years.

D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.

Specify if:
Early Onset: if onset occurs before age 6 years

Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder

A. Either (1) or (2):
(1) *inattention:* six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:
(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
(b) often has difficulty sustaining attention in tasks or play activities
(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish school work, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
(e) often has difficulty organizing tasks and activities
(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(2) *hyperactivity-impulsivity:* six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity
(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively

Impulsivity
(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorders, or a Personality Disorder).

Code based on type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months
314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months
314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months
Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

Diagnostic criteria for Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). **Note:** Only one item is required in children.

(1) restlessness or feeling keyed up or on edge
(2) being easily fatigued

(3) difficulty concentrating or mind going blank
(4) irritability
(5) muscle tension
(6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Diagnostic criteria for Adjustment Disorder

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

B. These symptoms or behaviors are clinically significant as evidenced by either of the following:

(1) marked distress that is in excess of what would be expected from exposure to the stressor
(2) significant impairment in social or occupational (academic) functioning

C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

D. The symptoms do not represent Bereavement.

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if:

Acute: if the disturbance lasts less than 6 months
Chronic: if the disturbance lasts for 6 months or longer Adjustment Disorders are coded based on the subtype, which is selected according to the predominant symptoms.

The specific stressor(s) can be specified on Axis IV.

309.0 With Depressed Mood
309.24 With Anxiety
309.28 With Mixed Anxiety and Depressed Mood
309.3 With Disturbance of Conduct
309.4 With Mixed Disturbance of Emotions and Conduct
309.9 Unspecified

Appendix F

Regression Analysis

Model:

$i = 1, \ldots, 80$ (respondent)

$j = 1, \ldots, 4$ (vignette)

π_{ij} is the probability of respondent i diagnosing on vignette j

$\Phi^{-1}(\cdot)$ is the inverse standard normal link

$\mathbf{x}_{ij}$ is the vector of regression variables (vignette or respondent characteristics)

β is the vector of regression coefficients (scaled to be Cohen's d)

u_i is respondent i's individual propensity to diagnose (the random intercept)

Then the mixed probit model is

$$\Phi^{-1}(\pi_{ij}) = \mathbf{x}_{ij}\,\beta + u_i.$$

Number of responses = 291

Number of respondents = 80

Average of 3.6 responses per respondent (i.e., some missing data but mostly complete)

Please note that more/other variables were not used in this model because the missingness of the variables removed respondents from the dataset. As many variables as possible were kept in the regression model, with the intentions of preserving the sample size and being meaningful to the results.

Chi square test for Model 2 (Design+Respondent) was compared to Model 1 (Design Model), and indicated 23.61(5), $p < 0.001$. The full model was chosen over the design-only model; the AIC statistically supports the choice.

Goodness of fit for the regression model was assessed using the deviance residuals. The deviance residuals, which are scaled to be z-scores, were examined to determine if the model fits adequately. Goodness of fit is supported because no evidence of misfit was found, and all residuals were within ± 2.

Table of Mixed Probit Regression Results Modeling Decision to Diagnose Vignette Clients

	Model					
	Null		Design		Design+Respondent	
Variable	**Coef.**	**Std. Err.**	**Coef.**	**Std. Err.**	**Coef.**	**Std. Err.**
Intercept	0.52	0.16	0.50	0.17	0.47	0.16
Gray Male Vignette			0		0	
Gray Female Vignette			0.11	0.22	0.09	0.22
DX Vignette			0.50	0.24	0.50	0.24
NDX Vignette			-0.37	0.23	-0.35	0.23
DSM Provided Form			-0.14	0.16	-0.27	0.14
Managed Care Form			0.13	0.16	-0.01	0.14
DSM × Managed			0.02	0.16	-0.16	0.15
Female Respondent					0.33	0.15
Respondent Diagnoses Off DSM					0.68	0.16
Adherence to APA Ethics Code					0.34	0.15
Agree with APA Ethics Code					0.20	0.16
Importance of APA Ethics Code					-0.32	0.16
Random Intercept SD	1.06	0.20	1.09	0.20	0.80	0.18
Intra-Class Correlation	0.53	0.09	0.55	0.09	0.39	0.11
-2 log-likelihood		342.86		335.15		311.50
Df		2		8		13
LR Test vs Prior Model			$\chi^2 = 7.71$, 6 df, $p = .26$		$\chi^2 = 23.61$, 5 df, $p < .001$	
AIC		346.85		351.14		337.49
Nagelkerke pseudo-R^2		0		0.09		0.33

References

Agresti, A. (2007). Introduction to Categorical Data Analysis, Second Edition. New York: John Wiley & Sons.

American Psychological Association. (2012). CE programs: Ethics in psychology. Retrieved January 12, 2012, from http://search.apa.org/continuing_education?query=&facet=cetopics:Ethics%20in%20Psychology&offset=2&sort=

American Psychological Association. (2012). Insurance and managed care. Retrieved from January 12, 2012, from http://www.apapracticecentral.org/advocacy/managed/index.aspx

American Psychological Association. (2012). Medicare reimbursement & access. Retrieved from January 12, 2012, from http://www.apapracticecentral.org/advocacy/medical/index.aspx

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. Retrieved December 1, 2009, from http://www.apa.org/ethics/code2002.html

American Psychological Association. (2002). Ethical Principles of Psychologists and Code of Conduct. *American Psychologist, 57,* 1060-1073.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th Ed.). Washington, DC: Author.

APA Center for Workforce Studies. (2010). 2010 APA Member profiles. Retrieved January 12, 2012 from http://www.apa.org/workforce/publications/10-member/tables.pdf

Aronson, Z. H., & Rielly, R. R. (2006). Personality validity: The role of schemas and motivated reasoning, *International Journal of Selection and Assessment, 14*, 372-380.

Auerbach, J. S. (1984). Validation of two scales for narcissistic personality disorder. *Journal of Personality Assessment, 48*, 649-653.

Baron-Cohen, S., Wheelright, S., Skinner, R., Martin, J., & Clubley, E. (2001). The autism spectrum quotient (AQ): Evidence from Asperger syndrome/high functioning autism, males and females, scientists and mathematicians. Journal of Autism and Developmental Disorders, 31, 5-17.

Bersoff, D.M. (1999). Explaining unethical behaviour among people motivated to act prosocially. *Journal of Moral Education, 28,* 413-428.

Brown, G. S., & Jones, E. R. (2005). Implementation of a feedback system in a managed care environment: What are patients teaching us? *Journal of Clinical Psychology, 61,* 187-198.

Brown, T. A, Sautter, J. A., Littvay, L., Sautter, A. C. & Bearnes, B. (2010). Ethics and personality: Empathy and narcissism as moderators of ethical decision making in business students. *Journal of Education for Business, 85,* 203-208.

Campbell, D. T. (1975). On the conflicts between biological and social evolution and between psychology and moral tradition. *American Psychologist, 30,* 1103-1126.

Cohen, J., Marecek, J., & Gillham, J. (2006). Is three a crowd? Clients, clinicians, and managed care, *American Journal of Orthopsychiatry, 76,* 251-259.

Corry, N., Davis Merrit, R., Mrug, S., & Pamp, B. (2008). The factor structure of the narcissistic personality inventory, *Journal of Personality Assessment, 90,* 593-600.

Crespi, T. D. (2004). Managed care: Implications for school psychology, *American Psychologist, 59,* 126-127.

Crespi, T. D. & Hughes, T. L. (2003). School-based mental health services for adolescents: School psychology in contemporary society, *Journal of Applied Psychology, 20,* 67-78.

Daniels, J. (2001). Managed care, ethics, and counseling, *Journal of Counseling and Development, 79,* 119-122.

Fisher, C. B. (2003). Decoding the ethics code: A practical guide for psychologists. Thousand Oaks, CA: Sage Publications, Inc.

Harmon-Jones, E., & Mills, J. (1999). An introduction to cognitive dissonance theory and an overview of current perspectives o theory. In E. Harmon-Jones & J. Mills (Eds.), *Cognitive dissonance: Progress on a pivotal theory in social psychology* (pp. 3-21). Washington, DC, US: American Psychological Association.

Hogan, R. (1969). Development of an empathy scale. *Journal of Consulting and Clinical Psychology, 33,* 307-316.

Hojat, M. Mangione, S., Gonnella, J. S, Nasca, T. Veloski, J. J., & Kane, G. (2001). Empathy in medicine education and patient care. *Academic Medicine, 76,* 669.

Israelashvili, M. & Socher, P. (2007). An examination of a counselor self-efficacy scale (COSE) using an Israeli sample. *International Journal for the Advancement of Counseling, 29,* 1-9.

Kielbasa, A. M., Pomerantz, A. M., Krohn, E. J., & Sullivan, B. F. (2004). How does clients method of payment influence psychologists' diagnostic decisions? *Ethics and Behavior, 14*, 187-195.

Koocher, G.P & Keith-Spiegel, P. (2008). Ethics in psychology and the mental health professions: Standards and cases. New York, NY: Oxford University Press, USA.

Kunda, Z. (1990). The case of motivated reasoning, *Psychological Bulletin, 108*, 480-498.

LaRoche, M. A., & Turner, C. (2002). At the crossroads: Managed mental health care, the ethics code, and ethnic minorities. *Cultural Diversity and Ethnic Minority Psychology, 8*, 187-198.

Larson, L.M., Suzuki, L.A., Gillespie, K.N., Potenza, M.T., Bechtel, M.A., & Toulouse, A.L. (1992). Development and validation of the counseling self-estimate inventory. *Journal of Counseling Psychology, 39*, 105-120.

Leite, W.L. & Cooper, A.L. (2010). Detecting social desirability bias using factor mixture models. *Multivariate Behavioral Research, 45*, 271-293.

Lowe, J., Pomerantz, A. M., & Pettibone, J. C. (2007). The influence of payment method on psychologists' diagnostic decisions: Expanding the range of presenting problems, *Ethics and Behavior, 17*, 83-93.

Mehrabian, A. & Epstein, N. (1972). A measure of emotional empathy. *Journal of Personality, 40*, 525-543.

Mehrabian, A., Young, A. L., & Sato, S. (1988). Emotional empathy and associated individual differences. *Current Psychology: Research & Reviews, 7*, 221-240.

Meser-Magnus, J., Viswesvaran, C., Deshpande, S. P., & Jospeh, J. (2010). Emotional intelligence, individual ethicality, and perceptions that unethical behavior facilitates success. *Revista de Psicologia del trabajo y de Las Organizaciones, 26*, 35-45.

Michaski, D.S., & Kohout, J.L. (2011). The state of the psychology health service provider workforce, *American Psychologist, 66*, 825-834.

Munro, M., Bore, M, & Powis, D. (2005). Personality factors in professional ethical behaviour: Studies of empathy and narcissism, *Australian Journal of Psychology, 57*, 49-60.

Pomerantz, A. M. & Segrist, D. J. (2006). The influence of payment method on psychologists diagnostic decisions regarding minimally impaired clients, *Ethics and Behavior, 16*, 253-263.

Pryor, L. R., Miller, J. D., & Gaughan, E. T. (2008). A comparison of the Psychological Entitlement Scale and the Narcissistic Personality Inventory's Entitlement Scale: Relations with general personality traits and personality disorders. *Journal of Personality Assessment, 90*, 517-520.

Racanello, A. M. (2010). *Too few symptoms to diagnose? A managed care ethical dilemma or a forgone conclusion?* Unpublished manuscript, PhD program in Educational Psychology, The Graduate Center, The Doctorate Granting Institution of the City University of New York, New York, United States.

Raskin, R. & Hall, C. S. (1979). A narcissistic personality inventory, *Psychological Reports, 45*, 590.

Raskin, R., & Terry, H. (1988). A principal-components analysis of the narcissistic personality inventory and further evidence of its construct validity, *Journal of Personality and Social Psychology, 54*, 890-902.

Reynolds, W. (2000). *The measurement and development of empathy in nursing*. Aldershot, England, Ashgate.

Rupert, P.A., & Baird, K.A. (2004). Managed care and the independent practice of psychology, *Professional Psychology, 35*, 185-193.

Rupert, P.A., & Kent, J.S. (2007). Gender and work setting differences in career-sustaining behaviors and burnout among professional psychologist, *Professional Psychology, 38*, 88-96.

Sanchez, L. M., & Turner, S. M. (2003). Practicing psychology in the ear of managed care: Implication for practice and training, *American Psychologist, 58*, 116-129.

Spreng, R. N., McKinnon, M. C., Mar, R. A., & Levine, B. (2009). The Toronto Empathy Questionnaire: Scale development and initial validation of a factor-analytic solution to multiple empathy measures, *Journal of Personality Assessment, 91*, 62-71.

StataCorp. 2011. *Stata Statistical Software: Release 12*. College Station, TX: StataCorp LP.

Tenbrunsel, A. E., & Messick, D. M. (2004). Ethical fading: The role of self-deception in unethical behavior. *Social Justice Research, 17*, 223-236.

Turchik, J. A., Karpenko, V., Hammers, D., & McNamara, J. R. (2007). Practical and ethical assessment issues in rural, impoverished, and managed care settings, *Professional Psychology: Research and Practice, 38*, 158-168.