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The Impact of Managed Care on Psychologists' Ability to Accurately Diagnose, Treat and Perceive Their Clients

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The Impact of Managed Care on Psychologists' Ability to Accurately Diagnose, Treat and Perceive Their Clients

by

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Report

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Abstract

The Impact of Managed Care on Psychologists' Ability to Accurately Diagnose, Treat and Perceive Their Clients

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It has been demonstrated psychologists are more likely to over-diagnose clients to obtain reimbursement if clients are using insurance (Pomerantz & Segrist, 2006). Although diagnoses are helpful in providing direction for treatment plans, incorrect diagnoses may be stigmatizing and result in flawed care (Wahl, 1999). Using an experimental design with video vignettes simulating therapy sessions, this paper will explore whether psychologists tend to excessively believe in false diagnoses when forced to provide them, as well as whether those labels negatively affect psychologists' opinions of clients. Hierarchical multiple regression will be used to determine if those in the group forced to diagnose a client tend to over-diagnose and have a more negative opinion of the client.

Table of Contents

"Faster than almost anyone expected, managed care has become the de facto national health policy."

George Anders (1996, p. 43)

Introduction

The concept of bias is defined at its most basic level as a prejudice or an unreasoned judgment ("Bias" n.d., para. 3b). More specifically, bias is an inclination to come to a conclusion about something or someone when information is only partially available. Often, such a lack of information serves to foster a one-sided, frequently erroneous point of view. Therefore, these preconceived notions created by bias inhibit people from impartially looking at the facts, and in turn, compel them to make unsound evaluations. According to Clifton Wilcox, author of *Bias: The Unconscious Deceiver*, this lack of neutrality can cause overarching biased perceptions, as opposed to a simple biased decision from time to time. Furthermore, Wilcox believes individuals' biased mindsets create more aggression and competition among groups and between persons, which can escalate conflict in general (Wilcox, 2011). All in all, this understanding of bias makes it clear that it can be a very destructive and detrimental force.

Given the idea that overarching bias is a product of continually making decisions with incomplete information, it would seem prudent to try to overcome this behavior via awareness of the tendency, and use cognitive exercises to seek out more information to try to remain unprejudiced. However, it turns out that bias stems from the very basis of our being, and it has a very strong evolutionary purpose. For example, a study using rhesus macaque monkeys established that monkeys are able to discriminate in-group and out-group faces, even when only viewing a static photograph. Once they made the determination of which monkeys were part of

their in-group, they devoted more vigilance toward out-group individuals than in-group members (Mahajan et al., 2011).

When viewing bias from this evolutionary perspective, it is easy to extrapolate how bias is hard-wired into us: the survival of early humans surely depended on being able to easily distinguish who is friend or foe. Quickly determining who was a member of the tribe, animals, and ultimately humans, became more protected; in other words, bias between "us and them" is evolutionarily wired in our minds to propagate and sustain our species. Haselton et al. (2005) explain in their chapter, *The Evolution of Cognitive Bias*, that from an evolutionary perspective, we fill in missing data by drawing inferences that are not always completely logical. They argue that biases are not "constraints or mysterious irrationalities," rather, they are mechanisms of our rationality and help us adapt and survive as a species (Haselton et al., 2005, p. 725).

Evolutionary psychologists also found biases offer shortcuts via heuristics, which lower resource costs, and aid the mind when one lacks an adequate schema (Haselton et al., 2005). Haselton et al.'s ideas stem from the works of Cosmides and Tooby (1994), who wrote that specializations in problem-solving, as opposed to a general-purpose problem-solving ability, actually make our mind more rational; they even found that this trait was favored during natural selection (Cosmides & Tooby, 1994). With these ideas in mind, it is unsurprising that humans with a strong disposition towards being biased have flourished in the evolution of our species.

As expected, humans are still engaging with their evolutionary tendencies for survival today. However, in the modern Western world, survival is not fostered through tribe membership, but instead has more to do with a social construction of friend and foe. For example, racism is a very obvious instance of Westerners' social construction of what is threatening: there is nothing inherently *wrong* with someone because his or her skin color differs

from one's own, yet racism – from individual hate crimes to institutionalized discrimination – has yet to be transcended in the West. As noted by Teresa Guess (2006) in her article, *The Social Construction of Whiteness: Racism by Intent, Racism by Consequence*, it is well accepted by social scientists that the notions of race and whiteness are constructed by the social meanings ascribed to them as opposed to any inherent meaning attached to them (Guess, 2006). Moreover, Lyman explains in his 1977 article, *The Asian in North America*, that it was the intersection of three significant events: "the conquest of the Indians, the forced importation of Africans, and the more or less solicited coming of Europeans, Asians, and Latinos," that solidified the tensions among race relations in America and helped to establish that Whites would hold power over people of color (Lyman, 1977, p. 25).

It follows then that race dynamics do not stem simply from a scientific perspective of bias, but rather, race superiority is informed by political, historical, and cultural biases. In other words, although people are biologically wired to protect their resources for survival, it is the social construction of racial superiority or inferiority that delineate who is perceived to be threatening. Therefore, when this socially constructed tendency towards fear of those of color combined with an evolutionary tendency to discriminate against out-group individuals, a culturally constructed bias against people of color became socially acceptable in the West. This has been demonstrated through research uncovering unconscious bias via the Race Implicit Association Test (IAT), which is a computer-administered test that measures the strength of association between race categories (i.e., Blacks or Whites) and positive and negative attributes (e.g., love or evil). To date, more than four million people have taken the test and have been found to have an implicit bias against Blacks, as they tended to sort words and images faster when White was paired with the positive attribute and Black with the negative attribute (Banks

& Ford, 2008). This finding highlights how evolutionary tendencies for bias are greatly strengthened – and become deep-seated and fairly unalterable – by culturally created biases, regardless of any personal desire to let go of said prejudices.

Presently, however, individual success is no longer predicated on tribal membership, but instead is defined by an individual's competency in his or her vocation. In other words, survival is now secured via the socially constructed mechanism of being employed and receiving a payment for one's work. Additionally, in order to stay contentedly employed within one's new "tribe" and continually receive a steady paycheck to survive, individuals have a need to experience meaning and purpose in life via their careers, as evidenced by vocational psychologists' research. For example, Duffy and Sedlacek (2007) found that the presence of a "calling" to one's work is positively correlated with "career decidedness, comfort, self-clarity, and choice-work salience," (Duffy & Sedlacek, 2007, p. 595). Additionally, Hirschi's (2001) article, *Effects of Orientations to Happiness on Vocational Identity Achievement*, compiles ideas from various psychologists, such as Martin Seligman and Mihaly Csikszentmihalyi, who both found that when people feel connected to their work they experience a greater level of overall happiness and connectedness, and thus have a greater chance of remaining gainfully employed (i.e., retain their means for survival) (Hirschi, 2001).

It follows that culturally constructed bias used to survive in today's world comes in this alternate form – in lieu of overt vigilance towards out-group members, people's biases manifest in a more insidious and surreptitious fashion: whether conscious or not, in order to feel connected to their work, people begin to accept their company's or field's principles as their own and behave accordingly. In modern times, this *professional bias* for the new "tribe" (i.e., their company or field) helps to ensure a paycheck, and ultimately, prolong survival and a sense of

well-being. In a vacuum, commitment and engagement to one's field could be seen as a positive factor, as employees with a more positive affect tend to be more productive and happier at work (Zelenskiet al., 2008). However, for mental health professionals, the aforementioned professional bias manifests by psychologists convincing themselves that over-diagnosing clients in order to ensure payment by insurance companies is reasonable. More specifically, this paper will explore how the professional bias by psychologists to over-diagnose their clients in order to ensure reimbursement (i.e., survival) has many consequences in regards to both their diagnostic skills and their attitudes towards their clients.

Integrative Analysis

The Growth of Managed Care

An understanding of the overall health care system in America is necessary to fully comprehend the state of the mental health care system. Over the past fifty years, the landscape of the health care system in America has changed drastically. The greatest shift in the health care milieu came with the Health Maintenance Organization Act (HMOA) of 1973, which inundated the system with an influx of managed health care firms. This modification ultimately allowed insurance companies to almost unilaterally control the business aspect of the mental health field for those psychologists who did not wholly subsist on private pay clients (Dorsey, 1975).

The HMOA of 1973 was enacted to facilitate the proliferation of managed care companies known as health maintenance organizations (HMOs). An HMO is akin to a prepaid health plan in which a monthly premium is paid to help cover all care. However, the client's choice of health care providers and facilities is limited to those willing to follow the HMO's policies and fee restrictions. The HMOA of 1973 helped HMOs proliferate by: a) requiring employers with 25 or more employees to offer federally certified HMO options if that employer typically offered other traditional healthcare options, b) offering government grants and loans to HMOs to start up or expand their business, and c) lifting state-imposed restrictions on federally certified HMOs (Dorsey, 1975, p.1 - 2).

In the early seventies the government believed HMOs would alleviate the rising costs of medical bills, as people would pay a fixed periodic payment for services instead of paying for costly individual services (Dorsey, 1975). The government hoped the comprehensive range of benefits offered through providers associated with HMOs would allow for less expensive fees and a broader range of coverage, as well as positively impacting the entire health delivery system

in America. Furthermore, it was assumed that health care would fare well in the free market, and "the activation of 150 million adult health care shoppers would dramatically transform the medical marketplace…," (Bartlett & Steele, 2004, p. 90). The powers in control at the time were correct that people would flock to these companies funded by the government and Wall Street: between 1976 and 1991, the number of those enrolled in HMOs soared from 6 million to 38.6 million people (Igelhart, 1992), and continued to rise exponentially, with an estimate of more than 70 million people associated with HMOs as of July 2011 (State Health Facts, 2011). Unfortunately, it was later found that human life is neither as stable nor as viable a trade commodity as an inanimate object; in other words, it was uncovered that free market trade as a means to creating a feasible health care platform led to an unstable system, which has been, and continues to be, hotly debated on a daily basis.

Accordingly, the question of whether managed care is beneficial for this country still remains. Proponents of HMOs would state they have increased efficiency, improved overall standards, and led to a better understanding of the relationship between costs and quality. On the other hand, critics of managed care argue the HMO movement was "defined by its organizational structure rather than its aims and performance," (Berwick et al., 2008, p.766). Berwick et al. (2008) reported that the restrictions in one's choice of providers and the perceived inaccessibility of specialists did not offset the monetary saving. Additionally, the government and HMOs overestimated the savings attached to proper preventive care, and the reliance on for-profit managed care companies has served as an unsuccessful health policy for the past three decades (Berwick et al., 2008). In reality, HMOs have contributed to higher health care costs, increased the number of uninsured citizens, driven away health care providers, and applied downward

pressure on quality, as reported by the National Committee for Quality Assurance (Himmelstein et al., 1999).

Furthermore, America spends $1.7 trillion on health care every year, roughly 15.3% of the gross domestic product, which is an amount that is abundantly larger than any other country and also a figure that increased 5.3% in less than twenty years (Bartlett & Steele, 2004, p. 94). Yet in 2002, when the World Health Organization created a formula to categorize countries around the world by subtracting years spent in poor health from the traditional life expectancy, the United States ranked 29th, between Slovenia and Portugal. The United States also spends 75% more per capita on health care than Canada, yet U.S. citizens live 2.5 fewer years, on average, than Canadian citizens (Bartlett & Steele, 2004, p. 12 - 14). It would seem the United States has yet to find a cost effective way to deliver state-of-the-art medical procedures to the vast majority of people to truly enhance the status of its citizens' overall health, while simultaneously overlooking the 45 million people who are still uninsured as of 2003 (Bartlett & Steele, 2004, p. 25). Lastly, it has been found that although HMOs may function well in communities with more than 360,000 people, they are not sustainable in smaller communities, which account for 27% of the population. Smaller communities are not able to afford the medical services and providers associated with complete care, such as inpatient and hospital coverage, and ultimately have to share facilities with other communities many miles away (Kronick et al., 1993, p. 150). This dearth of available services leads to longer-lasting illnesses and additional deaths (Bartlett & Steele, 2004). With these statistics in mind, it is clear managed care may be helpful to a portion of our country, but certainly marginalizes those without coverage, as well as those individuals in smaller and rural communities.

Managed Care's Impact on Mental Health

Even with these pitfalls, managed care companies are still the largest players in the health care market today, and consequently, the mental health care system is at the mercy of this standard as well. Prior to managed care's influx, psychologists would set their appropriate fees, and health insurance companies would reimburse clients a reasonable portion of that amount. However, after the arrival of the managed care system, clients were restricted to therapists in their insurance company's network who were willing to accept drastically-reduced fees. According to George Northrup, a past president of the New York State Psychological Association, "a psychologist working with managed care today receives a total fee about equal to what I charged in 1987. Adjusted for inflation, per session fees have declined 47% over that period of time," (Northrup, 2011, para. 5). Northup went on to note the mental health field was particularly susceptible to the pitfalls of managed care because its clients tend to be less assertive about their right to treatment due to their emotional distress while in therapy; therefore, it is easier for managed care companies to deny or restrict their treatments without clients putting up much of a fight (Northrup, 2011).

Managed Care Changes the Mental Health Landscape

With the flood of managed care companies, the entire practice of mental health has had to undergo theoretical changes over the past 35 years in order to remain a viable field. For instance, when Thomas Szasz (1974) re-edited his famous work, *The Myth of Mental Illness*, he chided the mental health community for falling prey to the desire of political interests who wanted to lump together medical diseases and mental problems. He believed that the government wanted to label people as "ill" to deprive them of liberty and responsibility on the grounds of a nonexistent

disease, which he argued was "a grave violation of basic human rights," (Szasz, 1974, p. xviii) . He also noted that "in modern medicine new diseases are *discovered*, in modern psychiatry they were *invented*," (Szasz, 1974, p. 12). Szasz undoubtedly believed in the validity of mental health problems, he just believed that categorizing them using labels that were created by the government and big business was a dangerously marginalizing path to follow.

Yet with the takeover by managed care companies, Szasz's ideas were disregarded in lieu of mental health professionals labeling every client to ensure reimbursement for services provided. Even without addressing the societal problems that Szasz outlined, choosing a label as a requirement for reimbursement became highly problematic, as diagnosing turned into a business transaction more so than a treatment-oriented procedure. Additionally, program development and policy-making in the mental health care field rely on reported rates of treated disorders, and when diagnoses are made mainly to appease third-party insurance companies, noise is introduced into these data which are used for mental health advancement and funding (Kirk & Kutchins, 1988).

Moreover, even honest diagnosing is problematic, as not every client fits neatly into a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM), the "bible" among mental health professionals used to label their clients (Kirk & Kutchins, 1988). Each individual's mental health problems are unique to his or her developmental history and cultural upbringing. Furthermore, it can be extremely difficult and fairly irresponsible to try to precisely diagnose a client after only one meeting, which is often a requirement of managed care companies (Shield, 2010). Managed care companies also try to determine the cost effectiveness of treatments via empirically validated outcomes, but there is little consensus among practitioners and insurance companies regarding the evaluation of effectiveness of mental health

treatment plans. More importantly, different treatments work for different clients, and those with chronic or severe mental illness may not show noticeable signs of improvement even if they are receiving exceptional care (Shield, 2010).

In his book, *Breaking Free of Managed Care: A Step by Step Guide to Regaining Control of Your Practice,* Dana Ackley (1997) notes that managed care "forced me to describe my work in terms ill-suited to my approach. The concepts managed care seemed to value had rarely been of much use to me when I was actually in the room with a human being," (Ackley, 1997, p. 5). As Ackley aptly describes in his book, the rigidly institutionalized way in which managed care companies handle reimbursement does not account for the human element of each case. He explains a universal treatment plan does not exist for each unique case of depression, posttraumatic stress syndrome, generalized anxiety disorder, etc…, and trying to fit people into fixed treatment plans restricts mental health professionals from providing high-quality therapy. Ackley further explains that continual distortions in clinicians' thinking due to the reliance on third-party reimbursement have affected both the psychologist's diagnostic skills, as well as negatively impacting the care the clients receive (Ackley, 1997).

Metzl also describes the cold and calculated system managed care uses in his 2001 article, *Psychotherapy, Managed Care and the Economy of Interaction*. He explains that under the "utilization management" system, psychotherapists must contact case managers who simply plug the client information into algorithms based on a decision tree analysis, which helps determine the "medical necessity" of each case (Metzl, 1998, p. 334). After a decision regarding the necessity of therapy has been made by a computer system and sessions are allotted by the insurance company, reviewers will then constantly check in on the treatment to ensure the sessions are being utilized efficiently. It is often the hope of the managed care company to

"restrict the accessibility and duration of psychotherapeutic treatments within their networks," (Metzl, 1998, p. 335). This stringent and detached system not only serves to deny clients the treatment they desperately need, but Metzl also argues throughout his article that psychotherapy is abundantly more valuable than managed care companies want to admit. He states that it keeps people healthier in various facets of their lives, including both mental and physical ways (Metzl, 1998).This lack of foresight and avarice in the moment by managed care companies is unethical, harmful to clients, and ultimately costs everyone more money in the long run.

Over-Diagnosing Becomes Standard Practice

As noted previously, humans are hard-wired to ensure their survival via payment through their vocation, and will fall prey to the professional biases that ensure this very survival. This argument begs the question: Could the financial incentives for payment create such a need to provide diagnoses for clients that mental health professionals actually begin to believe these diagnoses? Does managed care create this bias?

Previous studies have found that psychologists will tend to over-diagnose clients, especially when clients are using insurance. For example, in the Kielbasa et al. (2004) study, *How Does Clients' Method of Payment Influence Psychologists' Diagnostic Decisions?*, a written vignette of a client presenting with subclinical symptoms was sent to practicing psychologists to help determine if a client's payment method – managed care vs. private pay – affected the diagnosis provided for that client. Results of this study demonstrated the method by which a client was paying for psychological services did, in fact, influence their diagnosis. Specifically, relative to private pay clients, those who were paying via managed care were more likely to be

labeled with a DSM–IV diagnosis, most often receiving a diagnosis of adjustment disorder (Kielbasa et al., 2004).

Similarly, Pomerantz and Segrist (2006) followed up the Kielbasa et al. study by presenting a client with milder symptoms than the individual in the 2004 study, to further demonstrate that over-diagnosing was a product of the client's payment method as opposed to a lack of diagnostic skills on the part of psychologists. As hypothesized, their findings demonstrated once again that even when a client's presenting concerns fall well below diagnosable levels, those who are paying via managed care are far more likely to be given a DSM–IV diagnosis (Pomerantz & Segrist, 2006).

With these studies in mind, it is clear that the shift towards managed care has had an effect on psychologists' diagnoses. Not only are psychologists more likely to diagnose an insured client than someone paying out-of-pocket, but Peck and Scheffler (2002) believe that clinicians also engage in "intentional upcoding," a practice in which therapists exaggerate symptoms and diagnoses to increase the reimbursement amount offered by insurance companies (Peck and Scheffler, 2002, p. 1094). It is clear that these practices fall under the purview of insurance fraud, as well as breaking codes within the American Psychological Association's (APA) ethics code. Principle A: Beneficence and Nonmaleficence states that "psychologists strive to benefit those with whom they work and take care to do no harm," (APA's Ethics Code Online, Principles, para. 2). Clearly, when false diagnoses are offered, harm can be done to the client on multiple levels.

Implications of Over-Diagnosing

Based on the above arguments, it would appear that the professional bias to over-diagnose clients may be the most prudent choice for mental health professionals to continue to practice; if mental health professionals are unable to be reimbursed, clients will not receive treatment because those professionals will either refuse to accept insurance or will be unable to practice altogether. Although over-diagnosing may be a necessity, it creates other costs to both clients and practitioners. For one, over-diagnosing someone who presents with subclinical symptoms may force that client to hold an unjustifiable view of him or herself as mentally ill, which could actually intensify existing psychological concerns due to the anxiety attached to being labeled as sick (Caplan, 1995). Szasz also made the argument that labeling someone as "ill" makes it easier for both the sufferer and helper to accept a certain level of complacency that the situation will improve only a marginal amount since the person has a "real" illness. He went on to argue that humans have a fundamental need to order the world, and since "people tolerate uncertainty poorly, [they] insist that misbehavior must be classified either as sin or sickness," (Szasz, 1974, p. 39). Thus, over-diagnosing may make people believe they are more ill and less treatable than they actually are.

Additionally, the presence of a mental disorder on a client's permanent medical record, which may or may not be confidential, is often beyond the psychologists' control. A breach of confidentiality or a diagnosis on a permanent record could affect that client's future employment or future medical insurance, as well as cause them to feel stigmatized (Murphy et al., 1998). Furthermore, when psychologists over-diagnose clients, it is often the case that the treatment plan for that client will follow a prescriptive form based on that diagnostic categorization (Caplan, 1995). If the client is truly presenting with a milder disorder – or no disorder at all – the

plan for improvement will not be a viable one, and the client may not improve over time (Murphy et al., 1998).

Furthermore, in their book, *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders*, Kutchins and Kirk (1997) argue that escaping DSM labeling is an impossibility, due to being forced to adhere to the disturbing trend of "pathologizing everyday behavior." They find this especially problematic since they report the DSM lacks science and hard-evidence, which are supposed to underlie its creation; instead, they believe the DSM was and continues to be created via "political negotiation and advocacy – as well as personal interest" of those in power. They believe DSM diagnoses are created to pathologize the "undesirable and powerless," and those diagnoses are predicated on cultural biases (Kutchins & Kirk, 1997, p.16). Yet without an alternative method to diagnose clients, mental health professionals are forced into complicity in perpetuating the flawed system of managed care simply to stay in practice.

Stigma Affects Every Aspect of the Mental Health Field

The stigma attached to mental illness further complicates the issues surrounding over-diagnosing. Rosalynn Carter, an active advocate for mental health care reform, notes in her book, *Within Our Reach,* that the stigma – the label imposed by others that leads to devaluation and discrimination – attached to a diagnosis is insidious. She comments that people believe those who are experiencing mental illnesses are "considered to be lacking in judgment or weak-willed…seen as incompetent, unreliable, and unable to make decisions for themselves…can't work, hold public office…are dangerous, unpredictable, and violent…have brought these problems on themselves…and will never get better," (Carter et al., 2010, p. 4). The statistics that, on average, 70% of people interviewed in a national survey were unwilling to have individuals

with a mental disorder marry a family member and 60% were unwilling to work closely with them are even more disturbing. These statistics, combined with the fact that 1 in 4 people in the U.S. is diagnosed with a mental illness, demonstrate the harsh reality that stigma is alive and well in our society and affects at least 25% of the population (Carter et al., 2010, p. 5).

So, if we are over-diagnosing people and labeling them with erroneous diagnoses, how is this affecting their lives and relationships? One man who was diagnosed with Bipolar Disorder remarked, "What people believe about mental illness may be more disabling than the illness itself…would you ever believe that I'm capable of thinking intelligently and logically about things even if I was tied down twenty years ago and psychotic?," (Carter et al., 2010, p. 6). Carter goes on to explain that stigma remains as a result of a flawed impression that those with mental illnesses are violent. As it turns out, only 2% of all violence in America can be attributed to those *with* mental illness, while those who *have* mental illnesses are 4 times more likely to be the victims of violent crimes. Additionally, researchers from Mental Health America, a nonprofit mental health advocacy group, estimated that characters in the media (e.g., television, films, news stories, etc…) who are depicted as mentally ill are shown to be 10 times more violent than other characters, and 10 to 20 times more violent than real individuals who are mentally ill. Clearly, when there are already more than 60 million people diagnosed *each year* with a mental illness, this stigmatizing line of thinking must be addressed (Carter et al., 2010).

Exploring the Dangers for Psychologists of Over-Diagnosing

Given the idea that those with diagnoses are stigmatized, and the tendency to over-diagnose is the standard in the current health care system, the consequences of this trend need further exploration. For one, if psychologists are continually over-diagnosing their clients, is it

possible they start to believe their clients are sicker than they actually are and treat them accordingly? Could this practice of over-diagnosing become a conditioned response, and make diagnosticians lose their ability to diagnose accurately? Also, given the human tendency to stigmatize those who are mentally ill, is it possible that psychologists are not immune to this bias as well? Lastly, will psychologists ultimately have a more negative opinion of their clients, and potentially offer less compassionate and/or effective care? The current study intends to explore these topics using an experimental design that will simulate a managed care scenario to determine if the requirement for a diagnosis at the outset of treatment, and again after each successive session, will affect a psychologist's diagnostic judgment and lead to negative opinions about his or her client.

Proposed Research Study

Research Questions and Hypotheses

The current research study seeks to extend previous research findings by considering the negative aspects that are attached to the current model of diagnosing clients, especially when a diagnosis is forced by managed care. While research has begun to examine the relationship between forced diagnoses and the impact on psychologists and their clients, more information is needed concerning: whether mental health professionals are being conditioned to believe in erroneous and excessive diagnoses; the direct harm on the therapeutic relationship; and the therapist's potentially altered opinion of the client and how this may impact his or her psychotherapy.

Taking it one step further, it may also be likely that even when psychologists are no longer forced to diagnose their clients – e.g. they only take private pay or the Obama administration's proposed health care system changes – they will continue to do so based on their prior long-term conditioning resulting from managed care's criteria for payment. This is problematic since it has been found that labels indicating a psychopathology can often be a self-fulfilling prophecy for clients and ultimately hinder their improvement or worsen their condition due to stigma's stress (Link & Phelan, 2006). In addition, some evidence suggests that psychologists will often treat their clients less empathically once a severe diagnosis has been made, thus altering their attitude in a negative manner towards their clients, as well as impairing their ability to treat the client (Wahl, 1999). Furthermore, research has also demonstrated that any kind of psychological diagnosing increases the stigma people attach to being "sick" and "crazy," which already detrimentally plagues the mental health field; thus the more clinicians are

forced to diagnose their clients, the less interest the general public has in seeking the help they desperately need for fear of feeling stigmatized (Wahl, 1999). The problem of over-diagnosing, or indeed of making diagnoses at all, warrants further examination.

More specifically, this study aims to examine the following hypotheses and research questions:

Research Question #1: When psychologists must diagnose their clients for managed care, does this process of forcing a diagnosis make a psychologist more convinced that a diagnosis exists when it does not?

Hypothesis A: For many psychologists, once they make a diagnosis, they will start viewing their client through the schema of that diagnosis and believe it to be true without continual analysis. Thus, it is hypothesized that those who are forced to diagnose their clients throughout the study will be more likely to diagnose that client at the end of the study.

Hypothesis B: Psychologists who are consistently over-diagnosing their clients due to working with mostly insured clients will become conditioned to continually over-diagnose clients as times goes by. Therefore, it is hypothesized that those who are forced to over-diagnose clients in their every day practice will be more likely to diagnose the client in the experiment, regardless of whether or not they are forced to diagnose their client throughout the study.

Research Question # 2: Will forcing psychologists to diagnose a client negatively alter their overall attitude towards that client?

Hypothesis: Due to the natural tendency of humans to attach value judgments to those who are labeled as more pathologized, it is hypothesized that psychologists who are forced to diagnose their client throughout the study will have a more negative opinion of that person, and this negative opinion may impact the therapeutic relationship.

Statement of Purpose

The purpose of this study is to extrapolate beyond the findings introduced in the Kielbasa et al. (2004) and Pomerantz and Segrist (2006) studies, and determine the effect that over-diagnosing has on psychotherapy clients. It is important that this research goes beyond these previous studies, as they simply highlighted the fact that over-diagnosing is occurring within the mental health field. The methodology that will be employed in this study is designed to achieve all of the following main goals: to present realistic video vignettes, to assess psychologists' decisions regarding diagnosis under a simulated managed care setting and how stable those decisions are over a two month period of time, to better understand how psychologists attitudes towards their clients may change depending on whether or not they have an initial and continuing diagnosis, and to study a large and diverse sample of psychologists. The methodology seeks to extend research by (a) using video vignettes to allow for a more accurate and engaging simulation of therapy sessions; (b) experimentally manipulating groups to note differences in whether: (1) a client retains a diagnosis if he was originally diagnosed versus originally not diagnosed, and (2) there are differences in reaction to and attitude towards a diagnosed versus non-diagnosed client; and (c) controlling for any effect the demographics of the participant in relation to the client may have on the outcome variables.

Method

In order to assess the detrimental aspects of over-diagnosis, an experimental design will be employed in which six video vignettes of successive client sessions will be presented to randomly sampled licensed psychologists who are currently in practice. These licensed psychologists will be randomly assigned to one of two groups. Both groups will be identical,

except Group 1 will be forced to diagnose the client after each of the "sessions," while Group 2 will not be forced to make a diagnosis. Group 1 is intended to simulate the managed care environment.

Vignette Creation

Video vignettes will depict an early 30's, middle class, Caucasian male with mild symptoms of anxiety stemming from situational factors. The vignettes will begin with the first 10 minutes of an initial appointment, and then five subsequent five to six minute snippets of therapy sessions. Symptoms will include excessive worry, exhaustion, insomnia and irritability; in other words, the character will be in acute distress, yet under the threshold for a DSM-IV-TR diagnosis. By doing this, the study will be able to assess whether psychologists who are forced into making a diagnosis, as is the case in managed care settings, will readily over-diagnose their clients even when no diagnosis is warranted.

Two actors will be selected: one to portray the client and one to portray the psychologist. The vignette will only show the client. The psychologist will be out of view and will minimally interact with the client to allow space for the client to talk about his thoughts and emotions and to minimize the impact of the psychologist character on the research participants. The client's dialogue will not be scripted, but the actor will be given a general, basic overview of what will need to be covered. This general overview will be reviewed by two psychologists currently in practice to ensure the overview meets the research objectives. Several takes of the same scene will be filmed, and the best take will be used for each vignette.

Participants and Recruitment Process

Participants will be psychologists recruited through professional organizations across the country (APA, ACA, etc…) via email. Psychologists need to be licensed and practicing, working at least part-time (10 hour per week), engaging in psychotherapy work, as opposed to only assessment, outreach, career counseling, etc... No other exclusion or inclusion criteria will be required. A demographic survey each participant will fill out can be found in Appendix B.

Using G Power to assess sample size, it was determined that with a power level of .80, a medium effect size (.15), an alpha level of .05 and a total of 5 predictor variables in the largest model, 55 participants are required to participate.

Procedure

All participants will receive a link via email that will direct them to a Qualtrics survey with an individualized ID code in order to access the survey. This ID code will allow the researcher to pair participants' responses throughout the six week study period without having to collect identifying information. The first page of the survey will be the consent form (Appendix A) and the second page will be the demographic survey (Appendix B). Qualtrics will randomly assign participants to Group 1 and Group 2 as they log into the survey.

Both groups will then be directed to a page of text explaining the basics of the experiment and how it will include watching six vignettes of client sessions over a two month period of time. After reading this initial text, the client and vignettes will be identical for both groups. At this point, all participants will be directed to the first vignette, which entails ten minutes from the client's first session. During this session, he will outline the majority of his symptoms, which will include: excessive worry, exhaustion, insomnia and irritability due to a recent break up with

his fiancé. Each subsequent vignette will depict the client with a set of symptoms that are close to the threshold for a DSM–IV-TR diagnosis, yet never actually meet the criteria. The vignettes will also include background information about the client (e.g., gender, marital status, work, activities, etc...) to develop the character and make him seem more like an actual client rather than an abstraction or mere list of symptoms. The use of video vignettes, as well as the blend of symptoms with the background information, will all be utilized to depict a more realistic client. See Appendix C for an outline of each session.

After watching the first vignette, consistency will be established among the participants' experiences by asking them to watch the subsequent vignette at least five days after watching the first one, but no more than nine days later. This is to offer an experience akin to traditional therapy, in which clients are typically seen about once a week. The window of five to nine days will be offered to allow for some flexibility to ensure a lower rate of attrition. However, if a participant does not watch the vignettes within the specified period of time, he/she will be dropped from the study. Each participant will receive an email to remind him/her to log back into Qualtrics five days after he/she watched the previous video, and if he/she has not yet viewed the video by day nine, a reminder email will be sent asking him/her to watch the video by midnight that day.

At the beginning of each session, participants in Group 1 will be directed to a page that offers the following statement: "Simon's insurance requires you provide a diagnosis for him. As a reminder, after last session, you choose: [insert the previously chosen diagnosis]. Please keep in mind you will be asked to provide a diagnosis after watching the following vignette, as well; however, you do not have to remember the ICD or DSM numeric code." Group 2 will not be given this instruction. However, after Group 1 reviews their previous diagnosis, both groups will

be directed to an identical subsequent page and read the following statement: “Thank you for participating in this experiment. Please be sure to pay attention during the session to ensure you learn as much as you can about Simon. Additionally, feel free to write down notes you think may be important to help you remember the client for next week, which can be akin to case notes you typically write after seeing your own clients.” After watching the vignette, only participants in Group 1 will be asked to provide a diagnosis for Simon. It can be the same diagnosis as the one previously chosen or change after each session.

Immediately after watching the final vignette, participants will be asked to complete a questionnaire that will assess the following: attitudes about the client, desire to diagnose the client (with a suggestion of a diagnosis, if applicable), desire to work with the client if he has or does not have insurance, treatment plan options, and medication options. The full questionnaire can be found in the Appendix D. As a note, items 1, 2, and 4 will be used in the statistical analysis for this experiment, whereas items 3, 6, 7, 8 and 9 will be for exploratory purposes only.

Measures

A questionnaire was created to statistically assess participants’: (a) attitudes towards the client, as measured by chosen adjectives to describe the client, rated from a proffered list, (b) decision to diagnose the client and (c) desire to work with the client. Study outcomes were chosen to help assess psychologists’ tendency to over-diagnosis clients when forced to diagnose by managed care, as well as noting whether psychologists are more likely to retain an inaccurate diagnosis. Additionally, the outcome variable measuring psychologists’ attitudes towards their clients was chosen to assess whether attitudes towards a client are influenced by a client’s inaccurate and over-pathologizing diagnosis.

For item 1, a single mean composite score will be calculated for each participant by reverse coding the negative adjectives (i.e., letters: a, c, d, h, i, m, n, p, r, t and v), summing up the total for all of the adjectives, and dividing that number by the total number of adjectives. For the other two outcome variables (i.e., items two and four), a single mean score will automatically be calculated, as there is only one value for each of those items.

Furthermore, exploratory items will be included in the questionnaire to gather additional information for future studies. These items include questions such as whether or not participants would rather work with the client if he is insured versus paying privately, whether or not the psychologists would recommend an SSRI or anti-anxiety medication for this client, and a qualitative answer providing a proposed treatment plan. All of these questions will be useful in determining directions for future research.

Data Analysis

Hierarchical multiple regression analyses will be used to compare psychologists' responses between Group 1 and Group 2. A separate model will be created for each of the following dependent variables in the present study: (a) attitude towards the client (item 1), (b) likelihood of diagnosing the client (item 2), and (c) overall desire to work with the client (item 4). Additionally, a fourth model using an interaction will investigate whether prior conditioning due to every day over-diagnosing in participants' own practice moderates the relationship between the grouping factor and the desire to diagnose, as measured by item 2 (West & Aiken, 1991).

Within each one of these models, the demographics of the psychologist, including sex, years of practice and percentage of insurance taken, will be controlled for, as differences

between the psychologist and the client may affect the outcome variables. The above demographic variables will be entered into the model in the first step. The sex variable will be coded as 0/1, with males as the reference group (0). The treatment itself will be coded 0/1, with the control group (i.e., Group 2 – those not forced to diagnose the client) coded as 0. The rest of the demographic categories are quantitative and continuous, and do not need to be dummy-coded.

An initial analysis using a correlation matrix will be run on the data to check on the bivariate correlations, ensuring there are no perfect linear relationships between the predictors in order to meet the assumption of an absence of multicollinearity. Additionally, multicollinerarity will be assessed by examining tolerance after running the models. Independent variables with tolerance less than .2 will be considered multicollinear and removed from the model. Linearity and the presence of homoscedasticity will be assessed visually using a plot of residuals versus predicted values, and an absence of outliers will be examined by visually assessing a box plot of residuals. In order to assess the assumption of normality, P-P plots will be run and assessed to determine the normal distribution of residuals (Field, 2009). Participants with missing data will not be included in the analysis.

When running the hierarchical multiple regressions for each one of the dependent variables, the first block (step 1) will include all of the demographic information and the second block (step 2) will include the grouping factor. Since it is hypothesized that demographics relating to years of practice, insurance taken and the sex of the psychologist may affect the outcome variables due to differences between the participant and the client, it is prudent to control for them by entering them first, and then assessing the change in R^2 between the first and second equation created to ensure a significant change.

Lastly, to assess the hypothesis that psychologists become conditioned to over-diagnose clients, a hierarchical regression model will be run on item 2 (i.e., the likelihood of diagnosing the client), with the first block (step 1) to include the demographic information and the grouping factor, and block two (step 2) to include an interaction between the grouping factor and those who reported accepting insurance for 0 – 25 % of their clients (dummy-coded: 0) versus those who accept insurance for 76 – 100% of their clients (dummy-coded: 1). It is assumed that by incorporating the psychologists' tendencies in their own practice of whether or not they are accustomed to over-diagnosing (i.e., those who take more clients using insurance), long-term conditioning effects will be uncovered regarding diagnostic tendencies. Since it will be unlikely that large differences will be found between those in the 26 – 50 % or 51 – 75 % bracket, those individuals will be left out of the fourth regression model.

Results and Discussion

As argued in the aforementioned hypotheses section, it is expected that group affiliation affects the participants' perceptions of the client, the likelihood that the psychologist will diagnosis the client, and the level of desire of the psychologist to work with the client. More specifically, the first multivariate regression model, controlling for demographic factors, will demonstrate that participants in Group 1 were more likely to diagnose the client, on average, when compared to Group 2 participants. A statistically significant β for group affiliation will confirm this hypothesis. The second multivariate regression model, which will also control for demographic factors, will demonstrate that participants in Group 1 were more likely to agree with more negative adjectives about the client, on average, when compared to Group 2 participants. Again, a statistically significant β for group affiliation will confirm this hypothesis. The third multivariate regression model, which will also control for demographic factors, will demonstrate that participants in Group 1 were less likely to want to work with this client, on average, when compared to Group 2 participants. Again, a statistically significant β for group affiliation will confirm this hypothesis.

As for the fourth regression model, since it is hypothesized that those who over-diagnose their clients in their everyday practice will be more likely to be conditioned to over-diagnose them in this experiment, the results will likely demonstrate a significant interaction of grouping factor by level of insurance taken. In other words, the dependent variable of the likelihood of diagnosing the client will be affected by the percentage of insured clients the psychologists accepts in their every day practice. The significant interaction should likely reveal that those who work with 76 – 100% insured clients and are in Group 1 will be much more likely to diagnose the client than those in Group 2 who accept between 0 – 25% insured clients; thus, the

percentage of insured clients a psychologist accepts in their daily practice will moderate the relationship between the grouping factor and the likelihood of diagnosing a client. It is also likely, given the aforementioned hypotheses, that those in Group 1 who accept between 0 – 25% will not differ significantly when diagnosing the client than those in Group 2 who accept between 76 – 100%. This finding would reveal that those who are already conditioned to think more negatively and over-diagnose their clients (e.g., the psychologists who are forced to diagnose because they mostly take insured clients) think in that manner of over-diagnosing regardless of whether they are forced to diagnose from the beginning of this experiment or not.

Limitations and Future Directions

The results and conclusions of this study will be subject to numerous limitations. For one, its methodology involves video vignettes with less information than actual clients would yield. Secondly, the time and commitment involved with the design may make it difficult to retain participants. Also, the range of clinical issues presented in the vignettes will be limited to symptoms of anxiety, which do not represent the broad range of extant mental health disorders. The design is also limited by the fact that it is a single client represented, whose demographics may elicit reactions from participants that would be different if another actor had been chosen.

However, in spite of these and other limitations, the results of this study should illustrate the effect that the professional bias of over-diagnosing within the simulated managed care environment has on how clients are perceived and diagnosed by their psychologists. These tendencies will bring to light the problems in the grander scheme of the mental health field when considering the implications regarding: conceptualizing treatment plans, thoughts about suggesting medications, and the potential for marring the ability of psychologists to accurately diagnose future clients.

Regardless of the pitfalls of over-diagnosing described above, the system is established and entrenched, forcing psychologists to fall in line or go out of business. The conundrum psychologists face, therefore, is how to work within the confines of the managed care system so that they can continue to provide services to those in need, while still maintaining their ethics and maintaining the best interest of their clients. According to an article put out by the National Institute of Mental Health (NIMH), the Agency for Healthcare Research and Quality found that the cost in 2006 for mental health care in the U.S. was $57.5 billion, which is the largest amount for any single facet of health care – greater than cardiovascular disease, chronic respiratory

disease, cancer, or diabetes. However, it should be noted that the majority of that economic burden is a result of the "loss of income due to unemployment, expenses for social supports, and a range of indirect costs due to a chronic disability that begins early in life," (Insel, 2011, para. 1). In reality, it is a lack of available treatment for those with mental health problems that causes the bulk of the financial drain, not the cost of actual treatment for those in need. Furthermore, over the next two decades, mental illness is projected to account for more than 50% of the total economic burden from non-communicable diseases; and since those with mental illness are at high risk for developing cardiovascular disease, respiratory disease, and diabetes, one could likely estimate an even higher true cost of mental illness if all of these factors were taken into consideration (Insel, 2011).

With these statistics in mind, it becomes somewhat impossible to comprehend the master plan managed care has in mind for the mental health community. Not only are these companies denying people the care they require which would ultimately keep them healthier for a longer period of time, but this tactic is ultimately creating a larger bill for the managed care companies in the long term. Additionally, the general public is affected as well when mentally ill individuals go untreated or are misdiagnosed, since insurance rates often increase to cover the costs of mistreating existing clients (Kielbasa et al, 2004). It is clear that the system has to change for a multitude of reasons.

This research study will hopefully bring attention to the fact that managed care is impeding the ability for those with mental illnesses to receive appropriate care, corrupting the ethics and diagnostic skills of psychologists, and forcing a larger economic burden on itself and the public. Moreover, it is important that overall policy changes regarding mental health care access and the tendency to diagnose clients at all are explored in the future. Lastly, it will be

important to use the exploratory data gathered from the questionnaire to start investigating whether forcing diagnoses modifies a psychologist's treatment plan for a client, changes psychologists' thoughts about suggesting medications, and ultimately creates an overall less effective vehicle for psychotherapy in our country.

Appendix A

Consent Form

Consent to Participate in Internet Research

Identification of Investigator and Purpose of Study

You are invited to participate in a research study, entitled "Using Video Vignettes: A New Method for Assessing Clients and Treatment Options." The study is being conducted by Samantha Gaies in the Counseling Psychology PhD Program in the Department of Educational Psychology of The University of Texas at Austin. She can be reached via email at: samanthagaies@utexas.edu; via mail at: Educational Psychology, The University of Texas at Austin, 1 University Station D5800, Austin, TX 78712; or via phone at: (202) 834-4956.
The purpose of this research study is to examine commonalities and differences among psychologists' treatment plans for clients. You must be a currently practicing psychologist who provides at least ten hours of psychotherapy a week in order to participate. You are free to contact the investigator at the above address and/or phone number to discuss the study.

If you agree to participate:

- The entirety of the study will include watching video vignettes online, which depict successive therapy sessions for a single client. The first video clip is approximately ten minutes, and each of the five subsequent video clips will be roughly five to six minutes in length. You will be required to watch the succeeding video vignettes five to nine days after watching the previous one. You will only be allowed to watch the videos one time, but are welcome to take notes and/or pause it at any time. Additionally, you will read a short blurb of text prior to watching the videos, reminding you of the directions of the study. The time required to complete this study will be no longer than a total of 50 minutes over a two month period of time.
- After viewing the six vignettes over a two month period, you will be asked to complete a questionnaire regarding your thoughts about the client, as well as a treatment plan you would offer for him. This portion of the study should take no longer than 15 minutes to complete. Once the questionnaire is finished, you will be de-briefed about the study via email.

- You will be compensated for your time and participation in this study. After completing the entire study, you will be emailed a link to an American Express gift card. If you withdraw from the study early, there will be no compensation.

Risks/Benefits/Confidentiality of Data

There are no known risks. There will be no costs for participating, though you will receive a $50 American Express gift card for participating. Your name and email address will not be kept during the data collection phase, as you will have been assigned an anonymous ID code to log into Qualtrics. A limited number of research team members will have access to the data during the collection phase. No identifying information will be part of the dataset.

Participation or Withdrawal

Your participation in this study is voluntary. You may decline to answer any question and you have the right to withdraw from participation at any time. Withdrawal will not affect your relationship with The University of Texas in any way. If you do not want to participate, you can stop participating by closing the browser window and not logging back in the following week. If you do not want to receive the subsequent reminder emails, you may email us at samanthagaies@utexas.edu or follow this link to opt out of future emails [HTTP://LINK TO REMOVE].

Contacts

If you have any questions about the study or need to update your email address contact the researcher Samantha Gaies at 202-834-4956 or send an email to samanthagaies@utexas.edu. This study has been reviewed by The University of Texas at Austin Institutional Review Board and the study number is: ######.

Questions about your rights as a research participant.

If you have questions about your rights or are dissatisfied at any time with any part of this study, you can contact, anonymously if you wish, the Institutional Review Board by phone at (512) 471-8871 or email at orsc@uts.cc.utexas.edu.

If you agree to participate, click on the following link [HTTP://LINK TO STUDY]. Your ID number is: ###### and your password for the study is [PASSWORD].
Thank you.

Please print a copy of this document for your records.

Appendix B

Demographics Survey

1) Please fill in the following information:

   a. *Sex (check one)*: Male _____ Female _____

   b. *Age*: _____

   c. *Race (check one)*: Caucasian _____ Black or African-American _____

      Asian _____ Hispanic or Latino _____ Other _____

   d. Length of Practice (years): _____

   e. *Percentage of Your Clients Using Insurance:* _____

2) In a few words or a sentence, please describe your theoretical orientation towards psychotherapy:

_____

_____

_____

_____

_____

_____

Appendix C

Vignette Descriptions

Initial Session – Main Topics Covered

Simon, a 34 year old, single Caucasian male is coming in for therapy after he broke off his engagement to his fiancé six months ago. Prior to the break up, Simon had begun to feel angry and unappreciated, and attempted to communicate with her about their problems. However, after months of Simon imploring her to work on improving their relationship by going to counseling, she refused. After four months of fighting on a daily basis, he finally asked to take a break and moved out. Since that time, he has felt increasingly anxious, irritable, has had trouble sleeping and feels continually fatigued. During the first session, Simon will also disclose that he has a few very close friends who have been worried about him. They say he looks "ragged" and "exhausted" all the time, and his irritability has made him uncomfortable to be around; it was their urging that finally forced him to call a therapist. It will also be uncovered that Simon's parents divorced 5 years earlier, and although he gets along with both of them, the tension between his parents is also a cause of continual anxiety for him. Lastly, Simon will disclose that he has been working at a hospital as an ER doctor for the past 2 years, but his current level of anxiety has been impeding his ability to work; he noted he cannot think quickly enough and oftentimes second guesses himself in ways he never used to before breaking up with his fiancé.

Session 2 – Main Topics Covered

For the past few months, Simon will admit that his unusual fatigue has made it difficult to concentrate on anything, including his work, his social relationships or his hobbies, especially running and reading – two activities that used to help him calm down and center himself. He will report his family has been commenting on how withdrawn and scattered he has seemed lately, and although they understand his predicament, it has been of great concern to them given the contrast to his typical upbeat and friendly disposition.

Session 3 – Main Topics Covered

Simon will state he has a very demanding, high stress job, though also notes that he loves helping others. He will report he used to love the fast-paced nature of his work in the ER, but

again will reiterate his inability to work as efficiently and easily as he did a year ago. Simon has always identified himself as a high achiever, and his inability to work has been an extra burden on him. He has very high standards for himself and can be very self-critical when he fails to meet those standards. All of this, combined with the break up, has offered him significant feelings of worthlessness and shame due to his inability to perform as he used to in the past.

Session 4 – Main Topics Covered

Simon's insomnia has been keeping him awake, and as he tosses and turns for at least an hour or two before falling asleep, he will report spending most of that time thinking about his dissatisfaction with his life. He often laments to his friends – when he finally reaches out – that he feels like he will never again be happy, an effective doctor, or in a loving and stable relationship. However, if anyone tries to take him out to cheer him up, he oftentimes denies their request in order to "clear his mind" – which typically entails making lists of all of the negative aspects of his life.

Session 5 – Main Topics Covered

Simon notes that he is not suicidal, nor has he ever been, but he has been feeling pain and discomforts in various parts of his body. He says his back and neck have been feeling tight, and he has been having significant bowel issues, including diarrhea and constant nausea. Simon is very frustrated by these symptoms, as he knows there is nothing physically wrong with him, yet he cannot get rid of these physical ailments.

Session 6 – Main Topics Covered

Although Simon will report that he has not yet skipped a day of work, he worries that he would prefer to spend his days thinking about ways to fix his relationship with his ex-fiancé. However, he will also report that in those moments in which he spends hours ruminating about the situation, he always comes to the same conclusion that their relationship is unfixable, and this brings him back to a place of anger and irritability. He then withdraws from others even further, and spends the rest of his day/night thinking about how his life will never be what he thought it should be.

Appendix D

Questionnaire for Participants

1) Using the adjectives below, please rate Simon using the following likert scale:

1 2 3 4 5 6 7

Not at all like Simon ←----------No opinion ----------→ Very much like Simon

a. Hostile ____
b. Insightful ____
c. Labile ____
d. Overly emotional ____
e. Warm ____
f. Trustworthy ____
g. Self-discipline ____
h. Irritating ____
i. Blaming ____
j. Happy ____
k. Loving ____
l. Interesting ____
m. A "boundary pusher" ____
n. Vindictive ____
o. Thoughtful ____
p. Invasive ____
q. Easy going ____
r. Boring ____
s. Dramatic ____
t. Disruptive ____
u. Calm ____
v. Manipulative ____

2) **How likely would you be to diagnose this client?**

1 2 3 4 5 6 7

Very Unlikely ←----------Unsure----------→ Very Likely

3) **If yes, which diagnosis would you choose? _____**

4) **How much would you like to work with this client?**

1 2 3 4 5 6 7

Not at all ←----------Unsure----------→ Very much

5) **If you found out Simon would be paying out-of-pocket, how much would you like to work with him?**

1 2 3 4 5 6 7

Not at all ←----------Unsure----------→ Very much

6) **If you found out Simon could only be treated by paying with insurance, how much would you like to work with him?**

1 2 3 4 5 6 7

Not at all ←----------Unsure----------→ Very much

7) **Would you recommend an SSRI or anti-anxiety medication for this client?**

1 2 3 4 5 6 7

Very Unlikely ←----------Unsure----------→ Very Likely

8) **If yes, which one? _____**

9) **In a few short sentences, please describe the treatment plan would you follow for this client:**

_____

_____

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