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ABSTRACT

This paper describes the ethical dilemmas encountered by family counselors using the Diagnostic Statistical Manual of Mental Disorders IV (DSM). Numerous authors have emphasized that the DSM system does not contribute in an effective or efficient manner in the conduct of family therapy. The ethical issues of misrepresentation; trust; malfeasance; and confidentiality are presented within a family counseling context. Current solutions are reviewed including developing new diagnostic approaches, expanding the current DSM classifications, and adapting the current system. Recommendations are presented that address the need for setting a research agenda to develop a new system of diagnosis that is more compatible with a family systems counseling paradigm. (Contains 49 references.) (JDM)

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Running Head: ETHICAL ISSUES IN DIAGNOSIS

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The Use of DSM-IV in Family Counseling: Ethical Considerations

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Abstract

This article describes the ethical dilemmas encountered by family counselors using the DSM-IV. The ethical issues of misrepresentation, trust, malfeasance, and confidentiality are presented within a family counseling context. Current solutions are reviewed including, developing new diagnostic approaches, expanding the current DSM classification, and adapting the current system. Recommendations to address theses dilemmas calls for a setting a rigorous research agenda for the development of a new system for diagnosis which is more compatible to a family systems counseling paradigm.

The Use of DSM-IV in Family Counseling: Ethical Considerations

Over the years, mental health professionals have been practicing family counseling in increasing numbers (Huber & Baruth, 1987; Miller, Scott, & Searight, 1990). At the same time, the use of a formalized taxonomy for diagnosis in public agencies and private practice has become increasingly required (Smith & Kraft, 1983). However, little attention has been given to the ethical dilemmas created by the use of traditional diagnostic systems for family counselors (Denton, 1989).

The purposes of a formal diagnostic system are to aid in research, case conceptualization, and treatment planning (Kanfer & Saslow, 1965; Zigler & Phillips, 1961). However, traditional diagnostic systems, such as the Diagnostic and Statistical Manuals (DSM) (American Psychiatric Association (APA), 1980; 1987; 1994), have generally not been useful to family counselors (Wynne, 1991). This results from relational problems not receiving recognition as being equivalent to mental disorders which are individually defined (Shields, Wynne, McDaniel, & Gawinski, 1994).

Several studies have investigated the usefulness of the DSMs for mental health professionals, including marriage and family therapists. The results of a survey of practicing psychologists suggested that the DSM-II was rarely used for case conceptualization (Miller, Bergstrom, Cross, & Grube, 1981). In another survey of psychologists conducted by Smith and Kraft (1983) the results indicated that the DSM-III diagnostic system was considered less useful than other systems. Respondents in a survey conducted by Raffoul and Holmes (1986) indicated that social workers did not find the DSM-III helpful in treatment planning, in diagnosing marital

and family problems, or in accurately reflecting the problems of clients. Finally, in an investigation of marriage and family therapists conducted by Kirk and Kutchins (1988) it was found that 70% of the respondents believed that the DSM-III-R was not helpful in diagnosing marital and family problems.

However, formal clinical labels are frequently required by agencies, third party insurance companies, and government agencies (Denton, 1989; Kaslow, 1993; Kirk, Siporin, & Kutchins, 1989; Kutchins & Kirk, 1987; Schacht, 1985). The use of these codes is also required by the Health Care Financial Administration for reimbursement under medicare (APA, 1994). Thus, there are direct fiscal consequences of diagnostic practices (Kirk & Kutchins, 1988). While economics underlie the continuing use of DSM (Denton, 1989; Miller, et al., 1981,) this practice may place many family counselors in an ethical bind.

The potential for causing harm to either an individual family member or the family system is ever present. Kitchner (1986) notes that concerns have been raised about the potential harm caused by labeling. In traditional diagnostic systems it is assumed that the causes of psychological and behavioral problems lie primarily within the individual. These approaches ignore and at times conflict with the basic assumptions of family systems theory (Huber & Baruth, 1987) which focus on the relationships among people. Incompatible traditional diagnostic systems may result in ethical dilemmas for family counselors including issues such as misrepresentation, trust, malfeasance, and confidentiality.

Theoretical Frameworks

Medical Perspective

The traditional diagnostic system has been described as an objective-descriptive (Frances & Cooper, 1981; Havens, 1973), a biological and medical (Denton, 1989; Schacht, 1985), and a psychobiological (Fleck, 1983) approach. From this perspective, mental disorders are considered to be a dysfunction in the individual (APA, 1994). The solutions are based in medicine and education, with change directed at the individual (Cottone, 1989).

The medical approach is particularly concerned with the biological correlates of mental disorders (Shields, et al., 1994). In the DSM system an attempt is made to define these disorders within the realm of medicine (Kirk, et al., 1989). In the most recent revision of the Manual, DSM-IV (APA, 1994), attempts were made to move emotional disorders even closer to medical disorders (Kutchins & Kirk, 1987). APA states that

> . . . it should not be taken to imply that there is any fundamental distinction between mental disorders and general medical conditions, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes (p. 165).

A descriptive approach that attempted to be neutral with regard to etiology of psychology was introduced in DSM-III (APA, 1980). However, the DSM falls short of an atheoretical model. The basis of the Manual is a biological one (Singerman, 1981). Every decision tree in DSM-IV, like its recent predecessors, is hierarchical, and begins with a consideration of organic disorders (APA, 1994).

DSM IV disorders are described in terms of signs, symptoms, age of onset, course, prevalence, etc. (APA, 1994). APA (1994) uses a categorical classification system which is

traditionally used in all systems of medical diagnosis. The clinical diagnosis ascribes a label to an individual which signifies a particular pathology and set of symptoms (Keeney, 1979).

As Frances, Clarkin, and Perry (1984) acknowledge, "DSM was never intended to be, and clearly cannot be, a comprehensive statement of every variable important for treatment planning for all modalities" (p. 409). Considerable additional information must be gleaned from the individual to provide a comprehensive treatment plan; the DSM diagnosis is just the first step (APA, 1994). In APA's revision in 1980 an attempt was made to address Szasz's and others' criticisms that psychopathology primarily represented unpopular or devalued behaviors (Szasz, 1974). Focusing distress on the individual and separating the problem from the social context was one attempt to solve this problem (Kirk et al., 1989).

The multiaxial system, particularly Axes IV and V, was an improvement in assessing relational factors. APA (1980) recommended that family stressors be assessed on Axis IV. It also suggested that on Axis V adaptive functioning be assessed in terms of social context, one being social relations, particularly with family and friends. Although more emphasis was given to relational factors in DSM-III the relational context of the individual was not conceptualized for a systems perspective (Wynne, 1991). The inclusion of the multiple axes has allowed primarily for a more comprehensive assessment of the individual (Denton, 1990). Denton (1990) indicates that this is consistent with a medical stress diathesis model which views the social context as potential stressors for vulnerable individuals.

In DSM-IV (APA, 1994) additional attempts have been made to recognize the influence of the relational system on the individual. Axis IV has been changed from a vague rating scale for

the severity of psychosocial stressors to a more specific indicator of psychosocial or environmental problems. A specific category, problems with primary support group, has been included. These factors primarily address problems in the family. However, this does not represent a shift toward a systems orientation but allows for a more comprehensive assessment of the individual. When a relational problem is the focus of treatment, like its multiaxial predecessors, it is recorded as a V code on Axis I.

Another indicator that the traditional diagnostic system is taking relational factors more into account is the Global Assessment of Relational Functioning (GARF). The GARF was one of three proposed axes for inclusion in the DSM-IV. It was adopted as one of the axes proposed for further study and is listed in the Appendices of the Manual (APA, 1994). This scale evaluates the overall functioning of the family or relational unit on three dimensions: problem solving, organization, and emotional climate.

The importance of relational systems is receiving more recognition in the traditional diagnostic system reflected by DSM than it has in the past. However, V codes and auxiliary appendices are normally not reimbursable diagnoses. And for the most part, relationship concerns are viewed in terms of individual disorders by the DSM system (Cottone, 1989). As is stated in the DSM-IV, a mental disorder "must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual" (APA, 1994, p. xxi).

Systems Perspective

In the 1950's, the field of family therapy was initiated by practitioners with a differing orientation and their own distinct treatment strategies (Nichols & Schwartz, 1995). While there

are currently a number of different approaches to family therapy which emphasize unique styles of interaction and communication patterns (Segraves, 1982), general systems theory serves as the foundation of this perspective (Cottone, 1989; Denton, 1990; Shields, et al., 1994). The focus is on relationships among people rather than the processes occurring in an individual (Denton, 1989; Keeney, 1979).

Systems counselors consider symptoms of psychopathology as an integral part of relationships. In families with an identified patient, concerns are viewed as stemming from a relational context (Cottone, 1989). Thus, symptoms of psychopathology serve a function within the family system (Denton, 1990). Watzlawick, Bavelas, & Jackson (1967) propose that the individual behavior of family members is contingent upon the behavior of all members of the family. Therefore, problems in any part of the relational system may give rise to symptoms in other parts (Keeney, 1979). Psychopathology is viewed as relationship metaphors and as communications about relationships rather than as a problem within the individual (Keeney, 1979). In systems theory, the family is considered to be more than the sum of its parts (Watzlawick, et al., 1967). A family cannot be understood merely by understanding the individual members of the family (Denton, 1990).

Included in family therapy are the individual, the effects of the individual's behavior on others, the reaction of others to the individual, and the social context in which all of this occurs (Becvar, Becvar, & Bender, 1982). Interpersonal processes are examined initially when attempting to understand psychopathology. According to Shields, et al. (1994) "Family therapy does not ignore the intrapsychic or biological, but it does focus its vision, energy, and

intervention on personal relationships" (p. 118). Systems oriented counselors de-emphasize the individual and focus more on interpersonal relationships (Bateson, 1970). The therapeutic goal is the establishment of new relationship dynamics within the family system so that the pathological behavior is no longer necessary (Keeney, 1979). Thus, the systems-oriented counselor's first diagnostic task is to redefine the symptoms or problems from an individual perspective to an interpersonal one (Keeney, 1979). Psychopathology is then seen as part of a relationship system rather than centered in an individual.

Ethical Issues

Most ethical codes follow linear logic (Miller, et al. 1990) and thus are quite applicable to individual counseling and psychotherapy. Family counseling which is based on nonlinear reasoning and involves the rights of more than one individual, poses some unique ethical challenges. These challenges center around such issues as who in the family receives a diagnostic label, how this decision is reached, the treatment process and the therapeutic relationship, and the consequences and outcomes for the family.

Huber and Baruth (1987) suggest that traditional diagnoses support underlying pathological conditions within the family or the environment. Part of the initial goal in family counseling is to change the focus from centering on an individual family member to that of family interactions which can be supporting the individual's problem behavior. If family counselors use a systems approach with a family and then identify one person in the family as having the problem, this may appear to the family as support for their original perspective, that one family member is causing the family problems (Huber & Baruth, 1987).

There are also concerns related to financial reimbursement and traditional diagnostic systems. Haley (1987) believes that traditional diagnostic systems are basically incompatible for family therapists. The ethical issues in diagnosis in family counseling are complex and troublesome and involve critical therapeutic concerns centering on misrepresentation, trust, malfeasance, and confidentiality. Diagnosing individuals involves certain risks and imposes a grave responsibility (Denton, 1989).

Misrepresentation

Faulty diagnosis is one of the most frequent causes of psychotherapists' malpractice suits (Bernstein, 1978). Kutchins and Kirk (1986) state that diagnosis in mental health is a continuing problem since unintentional diagnostic errors are commonplace in the mental health professions. However, misdiagnosis is not confined to those with limited knowledge, careless assessment, or inadequate training. It is also a result of deliberate misdiagnosis (Kirk & Kutchins, 1988). Family therapists are likely to overdiagnosis or give a more serious diagnosis to a client than is warranted (Denton, 1989). Part of the cause of misdiagnosis can be found in the social context of clinical practice (Kirk & Kutchins, 1988).

Part of the dilemma encountered by family counselors stems from policies of insurance companies and other third party reimbursers to only provide payment for an individual mental disorder. Family problems are often seen by insurance companies as problems in living and not reimbursable (Denton, 1989). Many mental health professionals, including family counselors, use the DSM system primarily to obtain third party reimbursements (Smith, 1981). Packer (1988) calls this the "insurance diagnosis".

In an era when many clients use third party payments for family mental health services, family counselors may conceptualize and treat families using the systems model, and still another approach, the medical model, primarily to obtain payments. In the study of family therapists conducted by Kirk and Kutchins (1988), over 59% of the respondents were aware of Axis I diagnoses which were clinically unwarranted but were used to obtain insurance reimbursement. Seventy-two percent were aware of cases where more serious diagnoses were given to qualify for reimbursement. In addition, 86% acknowledged that diagnoses were often used for individuals when the primary problem was the family.

The rationale for overdiagnosis is primarily financial rather than therapeutic (Kirk & Kutchins, 1988). Although the reasoning of the counselor may be that this is being done in order for the client to obtain needed services, this may be clouded by the counselor's self-interest. Family counselors who provide a pathological diagnosis which they do not believe in and which is inaccurate, raise the ethical and legal issue of misrepresentation, which constitutes fraud (Denton, 1989; Packer, 1988). Such family counselors could be said to be sacrificing their integrity for material gain (Smith, 1981).

Although family counselors may consider this type of misrepresentation harmless or in the client's best interest, misdiagnosis has far reaching consequences. Kirk and Kutchins (1988) indicate that misdiagnosis has consequences in a number of arenas including professional practice, mental health agency policy and program development, government policymaking and third party payment. Kutchins and Kirk (1987) also suggest that problems resulting from deliberate misdiagnosis are compounded as treatment and custodial decisions as well as dispositions of civil

and criminal trials are often based on DSM diagnoses. Additional ethical issues are raised when diagnoses are misrepresented including trust, malfeasance, and confidentiality.

Trust. When family counselors deliberately misdiagnose, trust in the therapeutic relationship is violated. Clients are either deceived or manipulated (Kirk & Kutchins, 1988). Deceit may occur when families are informed that the symptomatic family member is not the problem, rather that these difficulties are familial in nature. And at the same time, counselors indicate to third party payees and in clinical records that one person within the family has the problem. It may also be considered deceitful when all family members are given DSM-IV diagnoses. This violates the systems theory principle of nonsummation, that individual diagnostic information of each family member cannot be summed to represent the entire family (Keeney, 1979). Harm may be caused to clients and trust violated by the use of deceit (Beamish, Navin, & Davidson, 1994).

Manipulation may occur when family members are encouraged to go along with an inaccurate diagnosis to obtain financial reimbursement. Since family counselors are in a position of culturally sanctioned trust, encouraging family members to agree to misrepresent their problems could be viewed as a gross violation of this trust. As Kirk and Kutchins (1988) suggest, one obligation of clinical practice is truthfulness. Family counselors are expected to abide by their own ethical codes and practice in a disinterested manner relative to payment. When diagnoses are made with insurance reimbursements in mind which misrepresent the client, the level of trust cannot help but be reduced. As Lippitt (1985) states, the level of trust between the practitioner and the client seriously effects psychological care. Practices which reduce trust will ultimately

affect the therapeutic relationship.

Malfeasance. Kitchner (1986) has warned of the negative effects of psychiatric labeling. Labels have the ability to deprive people of their uniqueness (Corey, Corey, & Callanan, 1984). This can lead people to giving up responsibility for change (Reich, 1981) and resigning themselves to being what is ascribed in their diagnostic label. Subsequent despair and self-fulfilling prophecies can result (Corey, et al., 1984; Van Hoose & Kottler, 1977). The stigma of a diagnostic label can also contribute to scapegoating within a family.

When clients are scapegoated within the family system as a result of labelling, they may be viewed by other family members as different. Labelling can be regarded as stigmatizing and likely to reinforce this view. As a result, family interactions may be shaped by these labels (Denton, 1989). This adds to the difficulties involved in obtaining support and achieving change. Overdiagnosis may therefore unnecessarily harm the client (Kirk & Kutchins, 1988).

Confidentiality. Problems in confidentiality also arise with diagnostic labelling. There are concerns regarding unintended uses of DSM diagnoses by other parties. Third parties have increased their demands to receive more confidential information about clients as they have become increasingly involved in the financing of counseling. Increasing demands include full treatment plans and progress reports to continue providing reimbursements.

Third parties can also obtain diagnostic information when clients are asked about past mental health treatment on job applications (Denton, 1989) and medical insurance applications. If clients are truthful and sign a release of information, prospective employers may have ready access to information the counselor thought was recorded in a confidential manner for the benefit

of family members. Family counselors should be very mindful of the far reaching consequences diagnosing.

Current Solutions

Most recently, family therapists have suggested several varying solutions to effectively deal with the ethical concerns in family counseling. These have included: developing new approaches for diagnosis; including new categories in the DSM; and, adapting the current classification system. Currently there is no widely accepted classification for family diagnosis.

An alternative paradigm for use in family therapy diagnosis, an ecosystemic epistemology was proposed by Keeney (1979). In contrast to linear epistemology which is exemplified by the medical model of psychopathology, relationship, ecology, and whole systems are emphasized in ecosystemic epistemology. The foundation of this approach is in a Taoistic way of knowing which emphasizes nonpurposive, process-oriented knowing or awareness of the whole system of which one is a part. Similarly, Auerswald (1987) points to the epistemological confusion in family therapy and suggests that the new way of thinking created by the pioneers in family therapy be recognized and accepted. "We humans need a new system of thought, a new edit of the universe for our very survival. There is such a system of thinking aborning" (Auerswald, 1987, p. 329).

Denton (1989) states that a system for classifying behavioral programs which reflects a systemic viewpoint needs to be created by family therapists. Family counselors would then need to negotiate with third party reimbursers for acceptance of such a classification system. If such an alternative diagnostic classification is accepted by third parties, marriage and family counselors

would no longer be bound to DSM diagnoses. Shields, et al. (1994) , however, suggest that the development of a new diagnostic classification system presents a formidable challenge to the profession. They indicate that as a profession family therapy has had a strong preference for nonempirical studies which makes it difficult to demonstrate its efficacy. The meaningful links between relational and mental disorders need to be culled from the literature and presented in a meaningful way. If the links are not readily available research should be undertaken to demonstrate these links.

Several new categories have been proposed for inclusion in the DSM. The Group for the Advancement of Psychiatry's Committee on the Family (1989) has argued that relational syndromes, those occurring between persons, often involve serious personal dysfunction and should be included as mental disorders. Wynne (1991) notes that family assessment could be addressed in the DSM by including it as a subcategory under adjustment disorder. He, however, points to a variety of difficulties. First, this would take the form of another global reference to families. In addition, the terms used in the DSM in the category of adjustment disorders he asserts to be too narrow for adequate use in diagnosing the full range of family disorders or other interpersonal relationships.

Frances, Clarkin, and Perry (1984) suggest that an additional axis be included in the DSM which would be used to rate family functioning to determine when family therapy is indicated. However, they concur with Shields et al. (1994) regarding the need for substantial research to be completed to test the variety of family classifications which exist to determine a reliable and valid system.

Adapting to the current classification system is another proposed solution. Denton (1989) and Wynne (1991) argue that family counselors who conceptualize systems beyond the family system may have fewer ethical dilemmas. Such an approach incorporates biological, individual, social, as well as family systems. This biopsychosocial model is based on the systems hierarchy (Engel, 1980). Denton (1990) notes, however, that the primary focus is still on the individual level not the family level.

Several researchers have expressed a concern with the almost exclusive reliance upon systems theory for regarding family dysfunction and treatment (Denton, 1990; Searight & Merkel, 1991). Denton (1990) warns of the potential risks of reductionism in any "pure" approach. In addition, the assumption that major psychopathology is always caused by family dysfunction has begun to be challenged (Denton, 1990; Shields, et al., 1994). Emerging viewpoints which address these issues have been suggested by Cottone's (1992) contextual paradigm and Searight and Merkel's (1991) contextual relativism which represents a greater awareness of the complexities of the roles of individual and family contexts.

Most recently, Kaslow (1993) describes several changes in the DSM-IV which will make it more useful for family therapists. These include: 1) the GARF, Criteria Sets and Axes Provided for Further Study, 2) The Relational Problems have been expanded in section for Other Conditions That May Be a Focus of Clinical Attention, 3) Axis IV has been changed to Psychosocial and Environmental Problems and, 4) Volume III of the DSM-IV source book includes an extensive literature reviews on Relational Problems.

Conclusions

Reliance on the DSM for reimbursement by third parties has created ethical dilemmas for family counselors. However, as Cottone (1989) states, "marital and family therapy cannot be viewed out of the context of a mental health delivery services in a competitive society " (p. 233). Yet, numerous authors have emphasized the fact that the DSM system does not contribute in an effective and efficient manner in the conduct of family therapy. The context or situation in which the pathological conditions occur is not considered in the DSM diagnostic system (Havens, 1985). Smith and Kraft (1983) suggest that the disease-based model of the DSM is used inappropriately in describing problems of living. In fact, nearly three-fourths of the respondents in their study of mental health professionals' preference for a psychosocial diagnostic option, indicated that most conditions in the DSM are clearly nonmedical problems in living.

In an attempt to explain this dichotomy, Denton (1990) maintains that the reason family therapists do not find the DSM more useful is that the scientific paradigms of the DSM and family therapy are incompatible. The DSM is identified with the medical or objective/descriptive model and family therapy with general systems theory. Thus, no indication of familial influences is provided in the DSM. However, it has been suggested by Shields et al. (1994) that many therapists believe that major psychopathology is "caused" by dysfunctions in the family. Clearly if a preponderance of mental problems are based in the family, then validation for and the importance of a family diagnostic system are evident.

With the increased professional recognition of marriage and family counseling and the apparent widespread discontent with the current diagnostic system, it appears that the time is indeed right for the development of a new taxonomy. Whatever obstacles have thwarted the

development of an alternative system of assessment, i.e., financial, time expenditure, or economic loss, marriage and family counselors are ethically bound to set a research agenda for the development of a new system for diagnosis. If this does not occur, clients can be assured that critical therapeutic concerns centering on misrepresentation including trust, malfeasance, and confidentiality will continue to exist.

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