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PSYCHODIAGNOSTIC COMPETENCE OF PSYCHOLOGISTS: INFLUENCES AND FACTORS OF DIAGNOSTIC ERRORS

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Abstract. *Diagnostic competence is a crucial factor in psychological practice, determining the accuracy and reliability of mental health assessments. Despite the growing body of research on clinical reasoning, psychology still lacks a unified framework for addressing diagnostic errors. This study synthesises psychology, cognitive science, and medical research findings to explore the cognitive, affective, and methodological factors influencing diagnostic accuracy. The analysis reveals that cognitive biases, such as anchoring and confirmation bias, significantly contribute to misdiagnoses. Additionally, affective influences, including countertransference and mood-congruent recall, further distort clinical judgment. Methodological inconsistencies exacerbate these challenges remarkably, as do the variability in DSM and ICD interpretations and the overreliance on subjective self-reports. The study proposes a structured approach integrating metacognitive training, standardised diagnostic tools, and interdisciplinary collaboration to address these issues. The findings highlight the necessity of improving clinical reasoning education, implementing cognitive debiasing strategies, and fostering a systematic methodology for psychodiagnostics. By enhancing diagnostic competence, psychologists can improve the accuracy of mental health evaluations, ultimately leading to better treatment outcomes and ethical professional practice. Moreover, the article emphasises the need to operationalise diagnostic competence as a measurable construct, linking it with clinical decision-making outcomes and error rates. It calls for longitudinal research to evaluate the effectiveness of educational and procedural interventions aimed at reducing diagnostic inaccuracies across diverse clinical settings.*

Key words: *diagnostic competence, cognitive biases, affective influences, clinical reasoning, psychodiagnostics, diagnostic errors, standardised assessment, interdisciplinary collaboration, mental health diagnosis, metacognitive training*

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ПСИХОДІАГНОСТИЧНА КОМПЕТЕНТНІСТЬ ПСИХОЛОГІВ: ВПЛИВИ ТА ЧИННИКИ ДІАГНОСТИЧНИХ ПОМИЛОК

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Анотація. *Діагностична компетентність є ключовим аспектом професійної діяльності психологів, що визначає точність і надійність оцінки психічного здоров'я. Незважаючи на критичну роль діагностики у психологічних втручаннях, сучасні дослідження недостатньо розглядають взаємозв'язок когнітивних упереджень, афективних впливів і методологічної необізнаності, що призводять до діагностичних помилок. У даному дослідженні узагальнюються результати з психологічних та когнітивних наук, а також медичних досліджень з виявлення основних чинників, що впливають на діагностичну компетентність. Аналіз показує, що когнітивні упередження, такі як ефект якоря, підтверджувальне упередження та евристика доступності, є значними чинниками некоректних діагнозів. Афективні фактори, зокрема контрперенесення та настрій-залежне згадування, спотворюють клінічне судження, тоді як методологічні недоліки – змінність інтерпретацій критеріїв DSM та ICD, а також залежність від суб'єктивних самооцінок – посилюють схильність у психологічній діагностиці до помилок. Для подолання цих труднощів у дослідженні запропоновано структурований підхід, що включає метакогнітивне навчання, використання стандартизованих діагностичних інструментів та міждисциплінарну співпрацю. Результати підкреслюють необхідність вдосконалення освіти щодо діагностичного мислення, стратегій когнітивного «дебіасингу» та впровадження систематичних діагностичних методів. Покращення діагностичної компетентності є необхідним для зменшення кількості помилок у психологічній практиці, покращення результатів лікування та забезпечення дотримання етичних стандартів у сфері психічного здоров'я. Крім того, у статті наголошується на необхідності операціоналізувати діагностичну компетентність як вимірювану конструкцію, пов'язану з результатами клінічного прийняття рішень і частотою помилок. Також висловлюється потреба в лонгітюдних дослідженнях, спрямованих на оцінку ефективності освітніх і процедурних втручань, що мають на меті зменшення діагностичних похибок у різноманітних клінічних контекстах.*

Ключові слова*: діагностична компетентність, когнітивні упередження, афективні впливи, клінічне мислення, психодіагностика, діагностичні помилки, стандартизована оцінка, міждисциплінарна співпраця, діагностика психічного здоров'я, метакогнітивне навчання.*

Introduction and current state of the research problem. Accurate psychological diagnosis is a fundamental pillar of effective mental care, directly influencing treatment outcomes, therapeutic relationships, and patients' well-being. Despite the progress of psychology, however, error in diagnostics remains a significant issue, often due to the complex interaction among cognitive bias, emotional factors, and the limitations of the assessment tools (Gonzales et al., Deming et al.) [7; 8]. While clinical reasoning and the process of diagnostics have been extensively examined in medicine (van den Berge & Mamede, Bukhari

et al.) [5; 20], psychology does not have a unified approach to the investigation of, and response to, error in diagnostics. At the same time, psychodiagnostic research has been focused on the inadequacy of the assessment tools and the accuracy of the diagnostic criteria, which do not adequately cover the cognitive and emotional factors underlying error in psychological judgment. This shortcoming points to the need for the application of an integrative approach to the investigation of diagnostics' competence in psychology.

One of the biggest challenges in psychological diagnostics is the inconsistency in the diagnostic frameworks, namely the application and interpretation of DSM and ICD criteria [8]. The definition of the term «serious mental illness» (SMI), for example, varies with no standard definition for use, leading to inconsistency in classification between research and clinical settings. The inconsistency mirrors the broader issue of the subjectivity of diagnostics, in which the training, preconceptions, and context of the practitioner are in ways which may not always align with standardised procedures. The use of self-report measures exacerbates the problem, and it is vulnerable to patient misinterpretation, social desirability bias, and distortion in recall, resulting in inaccurate diagnostics [7]. While structured assessment instruments with psychometric scales have been established to ensure objectivity, these are not immune to the problems, mainly when used in isolation of the clinician's critical thinking.

Another underdeveloped field in psychological diagnostics is the influence of affective factors in clinical decision-making. The emotional states of clinicians have been found to significantly influence the precision of diagnostics, with stress, fatigue, and personal bias leading to overestimation or underestimation of symptoms [12]. The phenomenon of countertransference, in which a clinician's emotional response to a patient guides the interpretation of symptoms, has been well studied in psychoanalysis but rarely brought into mainstream debate in diagnostic error (Gonzalez, Nielsen, & Lasater). Further, the mood-congruent recall bias, in which a depressed mood clinician will overreport pathological symptoms and an elated mood clinician will underreport, complicates the objectivity of diagnostics. While the influence of affective factors in decision-making in other healthcare areas is established (Ng et al.), psychology still lacks any systematic integration of these findings into diagnostics training and competency development.

Furthermore, there is a pressing need to examine the impact of cognitive bias in psychodiagnostic error. Medical science long ago established the role of heuristics in misdiagnosis, such as anchoring bias (reliance on initial impressions), confirmation bias (seeking confirmatory data for preconceived beliefs while ignoring counter-evidence), and availability bias (making a diagnosis in line with easily recalled cases rather than symptom prevalence) (Benishek, Weaver, & Newman-Toker) [2]. While such biases undoubtedly apply to psychological diagnosis as well, little research has been focused on investigating their specific contribution to clinical judgment in mental healthcare. Cognitive error is often compounded by high cognitive load and time pressure, particularly in clinical environments where psychologists must assess multiple patients briefly. Without systematic cognitive debiasing interventions, such conditions create a fertile field for error in diagnosis.

Notwithstanding these barriers, the debate about how to systematically increase the diagnostic ability of psychologists remains fragmented. While medical education has developed systematic diagnostic reasoning training (Schaye et al.) [17], psychology still does not have extensive metacognitive training programs explicitly addressing the mechanisms of error in diagnostics. There is little about interdisciplinary approaches to reducing diagnostic inconsistency, although collaborative consultations with other

mental health professionals have made diagnostics in clinical work more accurate [4]. By investigating how training approaches in medicine, nursing, and psychology overlap, this research seeks to recommend an integrated approach to increasing the diagnostic ability of mental health professionals.

This paper's central thesis is that improving psychodiagnostic competence in psychology requires an integrative strategy combining error reduction procedures at the cognitive level, control of the emotional/affective component, systematic protocols for diagnostics, and interdisciplinary collaboration. Combining the data of psychology, medicine, and cognitive science, this paper aims to fill an essential knowledge gap in the literature by presenting a general model for enhancing psychodiagnostic accuracy. The model indicates primary weaknesses in the dominant diagnostic procedures and presents suggestions for psychology instructors, clinicians, and researchers. In general, eliminating diagnostic fallibility is no intellectual exercise, but a necessity for providing ethical, evidence-based, effective psychological treatment.

The purpose and objectives of the study. This study aims to design a general framework for enhancing the diagnostic competence in psychology by integrating knowledge in cognitive science, clinical reasoning, and cross-disciplinary research. **Tasks**. By identifying the most prominent vulnerabilities in psychological diagnosis – cognitive bias, emotional factors, and methodological inconsistency – this study aims to 1) recommend evidence-based strategies, including the application of structured diagnostic tools, metacognitive training, and collaborative decision-making, for 2) enhancing the precision of diagnostics and the prevention of clinical error.

Research methods. This study employs comparative analysis and extensive literature review, combining outcomes in psychology, cognitive science, and medicine to investigate the determinants of diagnostic competence. A systematic review of the peer-reviewed articles emphasised cognitive bias, affective factors, variability in methods, and educational approaches in clinical reasoning. Comparative analysis was also used to ascertain the differences between clinical training in medicine and psychology and the best practices for implementation in psychodiagnostics. Conceptual synthesis is also employed in the study by combining theories of clinical reasoning, metacognition, and diagnostic decision-making to devise a single framework for increasing the precision of diagnostics in psychology.

The statement of the main material research. The complex interaction between cognitive, emotional, and methodological variables establishes psychological diagnostic competence. This paper synthesises the body of research to ascertain the most important vulnerabilities in the diagnosis process and how to rectify them. The findings are presented in four critical areas: cognitive bias in diagnosis, emotional variables in clinical reasoning, methodological issues in assessment, and how to enhance diagnostic competence. Based on the body of work and interdisciplinary research, this paper highlights the role of systematic diagnostic tools, metacognitive training, and interdisciplinary collaboration in reducing error and maximising the precision of diagnosis. The following sections detail these areas, discussing the problems psychologists face in diagnosing and the empirically supported interventions that can enhance clinical reasoning competence.

Cognitive biases are a leading reason for misdiagnoses in clinical psychology. Phua and Tan [16] indicate that most misdiagnoses result from heuristics – cognitive shortcuts clinicians take to make quick decisions, which can also lead to systematic error. Not only do the biases affect the decision-making of the individual, but the sociotechnical system in which clinical environments, availability of information, and decision-support

systems are present (Benishek, Weaver, & Newman-Toker) [2]. Common cognitive biases in clinical practice include: 1) Anchoring Bias. Psychologists might overrely on the initial information, leading to premature conclusions. The anchoring bias is particularly troublesome when the initial diagnosis is made, and the rest of the information is read in such a way as to support the preliminary assessment rather than investigate other options [11]. 2) Confirmation Bias. The propensity to search for and interpret information in agreement with preconceived notions while ignoring contradicting information. Research by van den Berge and Mamede [20] has established how physicians and psychologists fall into confirmatory inclinations unconsciously, reducing the flexibility in diagnostics. 3) Availability Heuristic. Professionals can make diagnoses with the most easily remembered cases, rather than objectively evaluating symptoms (Yuen, Derenge, & Kalman) [21]. The bias is increased by recent exposure to specific conditions, which overestimates their prevalence.

Benishek, Weaver, and Newman-Toker [2] highlight how such biases are rooted in humans' cognitive processes and driven by both personal ways of reasoning and factors at the systems level. Benishek, Weaver, and Newman-Toker contend that cognitive diagnostic error results from the combination of dual-processing mechanisms – quick, automatic Type 1 thinking and slow, deliberative Type 2 thinking. Type 1 thinking, particularly in the face of time pressure or cognitive load, makes one vulnerable to such biases.

Furthermore, van den Berge and Mamede [20] mention that dual-process theories of reasoning suggest that non-analytical reasoning is typical of clinical expertise, while reflective reasoning can be beneficial for complex case diagnoses. Their research supports the idea that «cognitive debiasing» – educating clinicians to think intentionally about how they make decisions – can reduce error by a substantial margin.

Cognitive biases are automatic, hence it is not easy to counter them. Structured reflection and metacognitive training have been proposed to counterbalance their effects. The following approaches are promising: 1) Metacognitive training and inciting clinicians to reflect through their decision-making process to detect bias (Yuen et al.) [21]. 2) Cognitive Forcing Strategies. Deliberately considering other diagnoses rather than depending on a preliminary impression [2]. 3) Decision Aids and Checklists: Systematic checklists consider all options (van den Berge & Mamede,) [20]. 4) Interdisciplinary Consultations: Seeking second opinions can offset personal diagnostic biases [11].

Benishek et al. [2] also argue that systems-level changes – such as implementing structured electronic decision-support systems and strengthening communication between teams – can decrease cognitive error by restricting the application of rule-of-thumb-based judgements. Cognitive error is inherent in the diagnostic process but can be managed through targeted interventions. Increased awareness of such bias and the use of strategies such as structured reflection, decision aids, and interdisciplinary collaboration can make diagnostics in psychology more accurate.

Besides cognitive bias, emotions also significantly impact decision-making in diagnostics. Liu, Chimowitz, and Isbell [12] mention how the clinician's emotional state can impact his or her judgement, leading to overestimation or excessive conservatism at times. Affect not only decides how psychologists process information but also how psychologists make decisions at conscious and subconscious levels [13].

The following are the recognised affective influences: 1) Mood-Congruent Recall: The psychologist in a lousy mood will focus more on pathology, while the psychologist in a good mood will report symptoms less (Ng et al., 2025). This is particularly troublesome in the context of mental health diagnostics since overestimation or underestimation of

symptoms may lead to misdiagnosis. 2) Countertransference: Personal response to a client may interfere with objective evaluation. Gonzalez, Nielsen, and Lasater) highlight the importance of training in recognising and managing countertransference in enhancing clinical judgment. 3) Stress and Fatigue: Emotional burnout and overwork can erode the accuracy of decision-making. Simmons [18] found that stress reduces the ability for reflective reasoning, leading to too much reliance on heuristics and intuitive choices.

Connor, Durning, and Rencic [6] argue that the emotional aspects of reasoning are undervalued in medical education but are significant contributors to diagnostic errors. They advocate for training programs that teach how emotion influences clinical judgment, like training programs that teach about cognitive bias. Similarly, van Baalen, Boon, and Verhoef [19] mention that including emotional awareness in clinical reasoning support systems could enhance decision-making by prompting clinicians to monitor their emotional status before concluding.

Ng et al. suggest clinical thinking should no longer be viewed as an exclusively cognitive process but as a blend of cognitive and emotional factors. They also present several pragmatic strategies to counter the impact of affect: 1) Mindfulness Skills: Teaching clinicians to be mindful of their emotions and regulate them can reduce the impact of mood-congruent recall. 2) Practices in self-reflection: Encouraging clinicians to think reflectively rather than relying solely on intuitive choices. 3) Emotional Regulation Training: Clinical training programs for managing stress and emotional burnout. 4) Supervision and Colleague Support: A formal forum for clinicians to discuss emotional struggles and countertransference concerns with their colleagues.

Identification of the role of affect in diagnostic thinking is the key to maximising precision and error prevention. Educational programs should include training in managing mood-congruent recall, countertransference, and impairment due to stress. Emotional awareness and resilience can be trained to increase the ability for objectivity in dependable decision-making in the diagnosis process.

Systemic problems in diagnostic procedures are a significant cause of errors, often leading to misclassification, misinterpretation, and diagnostic inconsistency. Bradford et al. [3] cover common limitations in diagnostic systems used in mental health, pointing out the following problems:

– Inconsistency in Diagnostic Criteria: Inconsistency in the application of DSM and ICD criteria can lead to disorders being incorrectly classified, especially for disorders like serious mental illness (SMI) without a standard operational definition in research and clinical practice [8].

– Dependence on Subjective Reports: Many psychological assessments depend on self-reports, which may be unreliable and susceptible to biases. Deming et al. [7] found that self-reported suicidal ideation and attempts varied significantly depending on the assessment method utilised, highlighting the risks of using inconsistent diagnostic tools.

Lack of Standardized Checklists: Unstructured interviews cause diagnostic inconsistency. Al-Khafaji et al. [1] conducted a systematic review that indicated structured checklists could reduce errors by ensuring rigorous symptom assessment.

One of the significant issues in psychological diagnosis is the lack of standard definitions of key terms. Gonzales et al. [8] conducted a systematic review of 788 studies that used the term «serious mental illness» (SMI) and found that 85% of the studies lacked an operational definition of the term. Among the studies that defined SMI, there was significant heterogeneity in diagnostic criteria, with some studies specifying only specific psychiatric diagnoses (e.g., schizophrenia, bipolar disorder). In contrast, others

included functional impairment or symptom duration. This heterogeneity creates issues in diagnosis, treatment, and policy making.

Similarly, Deming et al. [7] found significant differences in the assessment of suicidal ideation (SI) and suicide attempts (SA) through different methods, including interviews and self-report questionnaires. Their investigation revealed that confidential exit surveys resulted in the highest endorsement rates for SI/SA, demonstrating that evaluation context and perceived anonymity influence self-reported psychological symptoms. This difference is problematic as it challenges the reliability of self-report measures in clinical and research practice.

Reliability and Validity Problems in Psychological Testing.

One intrinsic methodological problem in psychological diagnosis is the reliability and validity of assessment tools. Psychological diagnoses are frequently founded on clinician judgment, which can be affected by cognitive biases, subjective interpretation, and training differences. As Deming et al. [7] note, inconsistencies in self-reported symptoms between assessment tools suggest that diagnostic categories could be less stable than assumed. These inconsistencies have severe implications for treatment planning and risk assessment.

Furthermore, Gonzales et al. [8] argue that the lack of a consensus definition for terms like SMI affects research generalizability and clinical utility. The fact that criteria vary across studies implies that research findings may not necessarily guide consistent clinical practice. This observation underscores the need for universally accepted diagnostic criteria and more precise assessment tools.

Strategies for Reducing Systematic Errors.

In order to alleviate these issues, several measures have been proposed: 1) Use of Standardized Diagnostic Criteria: Encouraging the use of more precise and consistent diagnostic definitions can help improve reliability. Researchers and clinicians need to work towards developing well-defined, evidence-based diagnostic categories to minimise discrepancies [8]. 2) Application of Structured Diagnostic Tools: Standard checklists and structured interviews have been shown to enhance diagnostic accuracy. Al-Khafaji et al. [2] found that structured diagnostic tools helped reduce errors through complete symptom assessment. 3) Multi-Measurement Methods to Self-Reports: Because of the inconsistencies in self-report data, Deming et al. [7] suggest using multiple measurement methods – such as combining structured interviews with confidential questionnaires – to increase diagnostic reliability. 4) Improved Clinical Judgment Training: Clinicians require training in order to minimise the effects of bias and inconsistency in diagnostic decision-making. This includes training in cognitive bias, systematic diagnostic techniques, and standardised assessment tools.

Systematic psychological diagnosis errors result from inconsistent diagnostic criteria, reliance on subjective report, and the lack of standardised assessment measures. Correction of these issues includes several methods, including standardising diagnostic terminology, using structured diagnostic measures, and using multiple evaluation methods to offer improved reliability and validity. Through improved diagnostic precision, psychologists can make more precise mental health appraisals and have improved patient outcomes.

Enhancing diagnostic accuracy requires psychologists to adopt evidence-based approaches to cognitive, affective, and methodological problems. Cognitive biases, emotional considerations, and systematic errors in diagnostic processes typically cause diagnostic errors. The literature suggests that structured training, inter-professional collaboration, and continuous professional development are needed to avoid diagnostic errors and enhance clinical reasoning (Brentnall et al.) [4]. Encouraging clinicians

to reflect on their reasoning is a significant strategy for reducing cognitive errors. Metacognition – the ability to reflect on one's thought processes – has enhanced diagnostic accuracy by allowing more awareness of cognitive biases and decision-making pitfalls [17]. Metacognitive training involves structured reflection, error-checking exercises, and critical self-assessment, which allow clinicians to be aware of when they might be over-relying on heuristics or intuitive judgment. The application of structured diagnostic checklists and decision trees standardises assessment and reduces variability in clinical decision-making (Brentnall et al.) [4]. Structured decision-support tools can help psychologists avoid over-reliance on intuitive reasoning, which has been linked to increased diagnostic errors. Huang et al. [10] developed the Clinical Reasoning Scale, which enhanced clinical reasoning in nursing students, suggesting that similar tools could be adapted for psychological diagnostics. Cognitive bias training programs and their impact on clinical reasoning can be important in enhancing diagnostic competence. Bukhari et al. [5] reported that final-year medical students who were given structured education on diagnostic reasoning enhanced their diagnostic accuracy in complex cases. The training should focus on identifying common cognitive biases, including confirmation bias (seeking information confirming an initial diagnosis) and availability bias (overestimating recently encountered cases). Seeking second opinions from colleagues can significantly reduce individual diagnostic errors. As Schaye et al. [17] investigated, establishing shared mental models allows clinicians to generate more consistent and correct diagnostic reasoning. Interdisciplinary collaboration fosters diversity in perspectives, opposing individual biases and improving diagnostic accuracy. Brentnall et al. [4] highlight that clinical reasoning is a critical skill for health professionals and needs to be systematically developed through training and assessment. Clinical reasoning involves: *g*athering and synthesising information*, g*enerating hypotheses*,* formulating a clinical impression, diagnosis, and treatment plan.

Nonetheless, an absence of agreement regarding how to teach and examine clinical reasoning is a barrier to effectively training clinicians. According to Brentnall et al. [4], though several tools have been developed to assess clinical reasoning, many are discipline-specific, which means they cannot be applied easily across professional groups. Future research needs to address the development of cross-disciplinary tools that psychologists, physicians, and allied health professionals can utilise.

One of the barriers to developing diagnostic capacity is the lack of structured feedback on clinicians' diagnostic reasoning processes. Schaye et al. [17] developed a clinical reasoning documentation assessment tool that provides structured feedback on diagnostic reasoning, making assessments more reliable. Huang et al. [10] also developed a validated Clinical Reasoning Scale to assess reasoning competency among nursing students. These tools can be adapted to psychology to strengthen training and assessment processes.

Improving diagnostic competence in psychology is a multifaceted challenge that requires metacognitive training, structured diagnostic tools, continuous education, and interprofessional collaboration. The literature shows that implementing structured feedback systems, standardised training programs, and evidence-based assessment tools can significantly enhance clinical reasoning. Future efforts must focus on cross-professional research to develop universal diagnostic competence models applicable to all health professions.

Teaching psychodiagnostics at the university level has its own set of challenges. Future psychologists must master a high degree of diagnostic skill that integrates

theoretical knowledge, practical skill, and the ability to negate cognitive and affective biases. Teachers play a vital role in learning these skills by designing effective curricula, organising systematic training procedures, and creating environments conducive to reflective practice.

The table 1 below outlines key challenges, causes, and potential solutions to the development of diagnostic competence.

Table 1

Common Challenges in the Diagnostic Process and Strategies for Improvement

Challenge in Diagnosis	Causes	Strategies for Improvement
Cognitive Biases (e.g., Anchoring, Confirmation Bias, Availability Heuristic)	Reliance on mental shortcuts, lack of awareness of biases	Teach cognitive debiasing techniques, structured reflection exercises, and use of checklists.
Over-Reliance on Self-Report Data	Patients may misrepresent or misunderstand symptoms	Train students in structured interviewing techniques and multi-method assessment.
Inconsistency in Diagnostic Criteria	Variability in interpretation of DSM/ICD criteria	Standardized training in diagnostic manuals with case-based discussions.
Emotional Influence on Judgment (Countertransference, Mood Effects)	Personal biases, emotional responses to clients	Teach emotional regulation strategies and encourage self-reflection.
Limited Exposure to Complex Cases	Lack of diverse clinical training opportunities	Provide simulated patient cases and supervised internships.
Lack of Systematic Approach	Intuitive rather than structured diagnostic reasoning	Implement diagnostic decision trees and standardized assessment protocols.
Insufficient Feedback and Reflection	Lack of self-assessment and expert review	Require reflective journals, peer review, and faculty feedback on diagnostic reports.
Difficulty in Integrating Multidisciplinary Perspectives	Limited exposure to interdisciplinary settings	Conduct joint case discussions with professionals from different fields.
Stress and Cognitive Load Impacting Decision-Making	High academic pressure and multiple simultaneous tasks	Teach time management, mindfulness, and workload prioritization skills.

Educators must provide a structured, reflective, and practice-oriented learning environment for students to develop strong psychodiagnostic competence. Teaching strategies should emphasise error prevention, metacognition, standardised diagnostic tools, and interdisciplinary collaboration. By addressing common challenges in the diagnostic process, educators can ensure that students acquire the necessary skills to become competent, accurate, and ethical psychological diagnosticians.

Conclusion and perspectives of further researches. Psychological diagnostic skill is a critical yet underappreciated area that directly affects the validity of mental health diagnoses, treatment outcomes, and overall patient outcomes. This study highlights the complex interplay between cognitive biases, emotional factors, and methodological errors underlying diagnostic errors. While there has been extensive research on clinical

reasoning in medical specialties, psychology has slowly adopted systematic frameworks for improving diagnostic accuracy. Addressing these shortcomings requires a multimodal approach using metacognitive training, systematic diagnostic tools, and cross-disciplinary collaboration.

Cognitive biases, such as anchoring, confirmation bias, and availability heuristic, continue to be pervasive in psychological diagnosis. Without structured interventions, these biases can lead to misdiagnosis, inappropriate treatment planning, and harm to patients in the long term. Affective influences, such as mood-congruent recall and countertransference, can also bias clinical judgment. While these influences are well established in psychotherapy, their impact on diagnostic reasoning is less addressed, and they must receive greater emphasis in training and professional development.

Methodological problems, such as inconsistencies between DSM and ICD criteria, reliance on self-reported symptoms, and the lack of standardised assessment protocols, also compound diagnostic errors. The fact that there are no universal standards for the definition of severe mental illness (SMI) speaks to the need for greater consistency in diagnostic systems. In addition, self-report data remains highly susceptible to distortion, pointing to the importance of using multiple evaluation methods and structured clinical interviews to enhance reliability. Improving diagnostic competence requires a paradigm shift in clinical practice and psychology education. Structured diagnostic checklists and decision trees can reduce assessment variability and improve consistency. Training programs should incorporate formal instruction on cognitive biases and methods of avoiding errors, fostering clinicians' ability to think about their diagnostic decisions critically. Encouraging interdisciplinary collaboration through consultations with other mental health professionals can also provide diverse perspectives that improve diagnostic accuracy.

Last, this study underscores the need for more evidence-based and systematic psychodiagnostics. Borrowing best practices from medicine, cognitive science, psychology, and future research and training programs can significantly reduce diagnostic errors and improve clinical outcomes. The development of diagnostic competence is not simply a professional obligation – it is an ethical imperative to render mental health assessment accurate, objective, and conducive to effective treatment.

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