

DIAGNOSTIC OVERSHADOWING

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Consultation liaison psychiatry services (CLPS) are, typically, based in a general hospital setting to provide the dual services of mental health clinical assessment/treatment and clinician support/education. The clinical and education roles overlap - a lot.

A significant part of the CLPS job is undiagnosing mental illness. Undiagnosis is often correcting a misdiagnosis, and also serves to validate the emotions and experiences of people (Patfield, 2011; Lakeman & Emeleus, 2014). It is not unusual for CLPS to be asked to see somebody who is emotionally overwhelmed or dysregulated. Sometimes this is in the context of mental health problems often in the context of significant stress. Naturally, we do not want to 'psychiatricise' the human condition. Of course, you cry when you are sad, and of course you are anxious when, like Courtney Barnett in 'Avant Gardener', you are not that good at breathing in. Of course, you're frustrated when you are in pain or do not understand what's going on.

Validating understandable and proportionate emotions is important.

It is equally important to make sure that somebody who has experienced mental illness previously does not have every presentation to the hospital/outpatient clinic seen through that lens. That is called "diagnostic overshadowing"; which is a significant problem.

Diagnostic overshadowing is where physical symptoms are overlooked, dismissed or downplayed as a psychiatric/psychosomatic symptom. It must be one of the most dangerous things that happen in hospitals.

The President of the Royal Australian and New Zealand College of Psychiatrists, Professor Malcolm Hopwood, said in May 2016, "I sometimes think that the worse thing a person can do for their physical health is to be diagnosed with a mental health disorder." Prof Hopwood cited stigma and discrimination in the health sector as contributing problems to early mortality amongst people with mental health problems.

People, hospital clinical staff included, are often shocked when they find out that people diagnosed with mental illness die between 10 and 25 years younger than the general public. Although suicide is a contributing factor to high mortality rates amongst this part of the community, it is alarming to note that the overwhelming majority - 86% - of people with mental health problems who had a premature death did not die from suicide (Happell & Ewart, 2016).

About 60% of people who experience mental health problems experience chronic physical health problems too. Poor mental health is a major risk factor for poor physical health, and vice versa (Harris et al, 2018).

The lived experience

Diagnostic overshadowing happens outside of hospitals too. In the example below, understandable and proportionate human emotions were misinterpreted as psychopathology. The cascade of events that followed makes for a sobering read:

Eight years ago I was diagnosed with bipolar affective disorder (BPAD) and recovered enough to commence a PhD. Unable to obtain travel insurance for a conference due to my diagnosis, I disclosed the reason to my supervisor. Unfortunately, he began to see all stress (normal to a PhD student) as BPAD symptoms and decided I was incapable of completing the PhD and progressively began to discriminate against me. My mental health started to decline. I imagine this must have validated his belief that I was an unsuitable student.

I received some help from the university, with an advisor indicating that my supervisor was undermining my work. The advisor was promoted. Despite not knowing me, his replacement did not believe my account and disagreed with my psychiatrist's assessment of my mental state. Other staff and graduate students joined the belief that I could not cope, alienating me from the entire department.

After almost 18 months of fighting, I was once again depressed and felt defeated. I left the degree and lost my scholarship. It was one of the hardest things I have done. After, I was unable to gain employment; overqualified for most positions, lacking experience for the rest, and no references. After five months of constant rejections and lingering grief from losing the PhD, my self-worth and coping ability were so diminished, I made a very serious suicide attempt. I was so distressed that I could not see another solution.

Seven months later and I still have no paid employment. I have been undertaking volunteer work to regain some meaning in my life and have set myself up for the long-term with a new field of study. However, this does not pay the bills, and living like this is taking its toll. Sometimes I do not know where my next meal will come from, I have lost friends because of their attitude towards mental illness, and have withdrawn from health-related activities because of a lack of finances. Most days I cope and can find meaning in what I do, some days are much harder.

Questions for Reflection

Assuming that you – the person reading this – is a health professional, we have some questions we would like you to reflect on.

Have I ever witnessed a person's mental health history influence how their presenting complaint was investigated or treated?

How does my workplace prevent mental health stigmatising and diagnostic overshadowing?

What can I do to support good holistic patient care without falling into the trap of diagnostic overshadowing?

References listed online @ meta4RN.com/shadow



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