Making a good mental health diagnosis

Science, art and ethics

CPD

Louise Stone, Elizabeth Waldron, Heather Nowak

Background
There are limitations to psychiatric classification, which affects the utility of diagnosis in general practice.

Objective
The aim of this article is to explore the principles of science, art and ethics to create clinically useful psychiatric diagnoses in general practice.

Discussion
Psychiatric classification systems provide useful constructs for clinical practice and research. Evidence-based treatments are based on the classification of mental illnesses. However, while classification is necessary, it is not sufficient to provide a full understanding of 'what is going on'. A good psychiatric diagnosis will also include a formulation, which provides an understanding of the psychosocial factors that provide a context for illness. Experiences such as trauma and marginalisation will change the illness experience but also provide other forms of evidence that shape therapy. Diagnoses also carry ethical implications, including stigma and changes in self-concept. The science, art and ethics of diagnosis need to be integrated to provide a complete assessment.

PSYCHIATRIC DIAGNOSIS is difficult. A good diagnosis provides a valid interpretation of a person's experience and is respectful and empowering. It should also capture what is known about the causation and course of the illness, and it should be clinically helpful, guiding the doctor and the patient towards evidence-based treatment.[1] Good psychiatric diagnosis weaves together the 'warp' threads of scientific classification with the 'weft' threads of lived experience to enable a clinician and patient to come to a common understanding of 'what is going on'.[1]

In this article, the authors will examine the principles used to craft a good diagnosis, using science, art and ethics to create an accurate, comprehensive and helpful framework for patient care. Throughout the paper, the authors will discuss the following case of Aditya, a child with significant psychological distress.

CASE

Aditya is boy aged 10 years who presents with his mother, Nisha. Currently, Nisha and her husband, Amandeep, are negotiating an acrimonious divorce. They have had significant conflict since they migrated to Australia 12 years ago. Aditya has one older sister and a younger brother, both of whom seem to be doing well. Nisha is concerned because Aditya has been refusing to go to school. Aditya says he is 'dumb', unlike his brother and sister, and 'everyone at school hates him'. His teacher has noticed that he cannot focus at school and often has emotional outbursts when he cannot manage his work. She has also commented that he seems anxious, especially when he is asked to try something new, and does not cope well with changes in routine. Nisha says that Aditya has always had difficulty making friends, and he spends hours playing with his Lego. Nisha has noticed that he becomes distressed by noise and is very particular with the way his room is organised, becoming distressed if objects are moved. Nisha wonders if Aditya has anxiety.

Science: The accurate diagnosis

Science is embedded in the work of medicine, and because it is an integral part of the culture of clinical care, it can be difficult to recognise and acknowledge its limitations. Recent classification systems such as *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, and *International Classification of Diseases*, 11th revision, have emphasised the importance of reliable, objective criteria

to ground their diagnostic frameworks.[2] The diagnoses contained within these taxonomies form the basis of evidence used to justify treatment options. Scientific method has underpinned research into the neurology, endocrinology and immunology of the major mental illnesses[3] and provided some evidence of the efficacy of treatments, including medication and psychotherapies.[4–6] Psychiatric classification also enables consumers and carers to access information about their illness, understand why they experience the world the way they do and connect with others who share their situation.[7]

However, there are limits to the utility of scientific classification in psychiatry.[4,8–12] While some diagnostic classifications have remained relatively stable over time (eg schizophrenia),[13] others have changed significantly (eg hysteria).[14] Some diagnoses have disappeared (eg homosexuality),[15] while others have emerged (eg various categories proposed for internet addiction).[16] The lack of stability in psychiatric diagnostic systems reflects the complex nature of psychiatric illness and the role of social expectations on society's understanding of a 'disorder'.[17]

The boundary between wellness and illness in psychiatry is highly contested,[10,17] with some authors asserting that psychiatry 'medicalises misery'.[18] General practitioners (GPs) are often asked to decide with patients when stress becomes an anxiety disorder, or sadness becomes depression, and the boundary is difficult to define.[19] Often there is an ethical dimension to this decision, which is discussed later in this article.

Comorbidity is common in psychiatry, both with physical health disorders and between psychiatric disorders.[20,21] The features of psychiatric disorders can overlap.[17] Choosing the 'correct' diagnosis can be challenging, especially in young people where the disorders are evolving. Because of this overlap, psychiatric assessments need to explore the breadth of symptoms and include a mental state examination (Box 1). Some symptoms – such as hallucinations, disordered eating or compulsive behaviours – are difficult for patients to disclose because of shame and stigma.[22,23] Therefore, assessment needs to be thorough before a diagnosis is made. Premature closure of the diagnostic process is common and leads to incorrect diagnoses and inappropriate treatment. Misdiagnosis through premature closure causes iatrogenic harm.[24]

Some mental health organisations encourage a simplified process of diagnosis, using tools in less-expert hands to screen and categorise patients.[25] In some cases, they enable patients to self-diagnose using online tools.[26] It is a seductive model, where simple diagnostic tools lead to a psychiatric diagnosis, which then guides evidence-based therapy.[27] However, diagnosis can be complex and evolving, and simple tools may not capture

Box 1. Making an accurate psychiatric diagnosis[52]

Psychiatric diagnosis is complex and involves history-taking and evaluation. General practitioners (GPs) may know many of these aspects of the patient's history, but it can be helpful to revisit these factors as the circumstances and patient insights may change over time.

1. Screening: It is not uncommon for patients to have completed a screening tool prior to the assessment. Remember that screening tools are not diagnostic, so the GP needs to do a complete assessment before committing to a diagnosis.
2. Current concerns: This includes exploring specific symptoms, the context (including events leading up to this presentation), the time frame and whether symptoms fluctuate, the factors that exacerbate or reduce symptoms and the history of past treatments. Remember to ask specifically about symptoms that may be difficult to discuss, including suicidal thinking.
3. Developmental history:[53] This involves exploring childhood experiences, environment and relationships, and includes trauma histories, interpersonal relationship challenges and physical health issues, such as chronic illness. Remember that the impact of adverse childhood experiences is cumulative, so although GPs do not need to know exactly what occurred in childhood, patients who recount multiple instances of trauma are more at risk than those who have experienced a single incident. Trauma histories need to be explored sensitively, because the risk of re-traumatisation is high. In general, it is more important to understand that trauma occurred than to ask a patient to recount the nature of that trauma in detail.
4. Family history
5. Past medical and psychiatric history
6. Drug and alcohol history
7. Premorbid personality: In order to facilitate recovery, it is important to understand who the person experiencing the illness really is. A good question is 'can you tell me what you were like before you became unwell'?
8. Current social situation: Remember to ask about dependents, safe housing, exposure to ongoing violence and financial concerns, as these will impact recovery and capacity to access treatments.
9. Mental state examination: A mental state examination contains observations relating to
   - appearance, behaviour and rapport
   - speech (eg rate, dysphasia or problems with articulation)
   - mood (the internal feeling as described) and affect (the observed emotional response)
   - thought disorders (including abnormal content – such as delusions, overvalued ideas, suicidal thoughts, obsessions or phobias – and thought process – such as disorders of the form, stream or possession of thoughts)
   - perception (eg hallucinations)
   - cognition (often measured by a mini-mental state examination)
   - intelligence
   - judgement
   - insight.
10. Physical examination and investigations: It is important to detect and manage comorbidities in patients with a mental health concern, especially if organic cerebral pathology is suspected.

this complexity. In general practice, there is an opportunity to re-evaluate psychiatric diagnoses over time. Diagnoses such as bipolar disorder, neurological diseases and postnatal anxiety, for instance, are frequently misdiagnosed as depression.[28–30] It can therefore be beneficial to revisit the diagnosis periodically to see if comorbidities emerge or the primary diagnosis changes.

Generalisation of treatment options on the basis of categorical diagnosis can also be challenging. Most of the evidence for treatment has been generated with tightly defined populations with one disorder only, often in its first episode.[5,31] This means that the ability to generalise this evidence to patients with complex multimorbidity is limited.

The case of Aditya offers a brief description of a child experiencing psychosocial difficulties. If Aditya is sufficiently distressed to reach the threshold of a disorder, scientific diagnosis can offer a number of opportunities to improve his wellbeing. Aditya may well demonstrate features consistent with anxiety, including the subtypes of social anxiety and obsessive compulsive disorder. He may also meet the criteria for attention deficit hyperactivity disorder or autism spectrum disorder. Each of these diagnoses offers a different understanding of 'what is going on' and a series of options for evidence-based therapy. An accurate diagnosis, or diagnoses, offers Aditya, his family and the GP options for treatment that may improve Aditya's life.

However, it could easily be argued that none of these diagnoses acknowledge the trauma of his parents' divorce, the potential for abuse in the family or any cross-cultural experience in the classroom. In order to manage Aditya's distress, it is important to consider a more comprehensive understanding of 'what is going on' and combine this with the diagnostic classification.

Art: The comprehensive diagnosis

Psychiatry has a long history of narrative diagnosis, understanding why people are the way they are by exploring their life histories.[1,32] In general practice, it is common to understand a person's distress by understanding their context and what has happened to them in their lives.[33] Psychiatrists call this way of knowing a 'formulation' (Box 2). In general practice, the formulation is usually built up over a series of consultations as GPs come to know their patients over time in the context of a trusting therapeutic relationship. During this time, GPs and their patients create a shared explanation that often forms the basis for psychological interventions.

Formulations are critical in understanding trauma, which can have a pervasive impact on a person's life and health.[34] They are also critical in understanding a patient's sociocultural context, especially when the patient comes from a context different to the clinician's.[35] Clinicians and patients are people, whose characteristics form a key determinant of the shape of their therapeutic relationship.[34] Many diagnoses are culturally bound and influenced by social expectations and stereotypes,[32,36,37] including gender, ethnicity and socioeconomic status (Box 3).

If symptoms arise from biological phenomena, it would logically follow that diagnoses reflect an objective 'problem' that can be found and 'fixed' within the individual.[38] This approach can be particularly damaging to individuals who experience marginalisation and oppression related to a characteristic that is a core part of their identity.[2,39] In such a case, distress is a reasonable reaction to societal conditions that the individual has limited capacity to control.[40] Treatments or diagnoses that focus on individual responsibility for mitigating this distress imply a responsibility, on the part of the individual, to manage the friction between social expectations and their own identity. A formulation helps a GP understand what external factors influence the patient's presentation, and it enables a discussion with the patient to decide whether to focus on individual therapy or on managing difficult external circumstances (eg managing discrimination and harassment in the workplace or school).

Diagnoses can have overlapping diagnostic criteria, which has contributed to the prevalent overdiagnosis of more severe conditions in marginalised patients (Box 4).[41,42] Patients judge which symptoms to relate, how to describe them, how likely their clinician is to believe some when compared with others, and how their own appearance

Box 2. Making a formulation[54]

A formulation provides an explanation that answers the question 'Why is this person unwell in this way at this time?' It uses biological, psychological, social, cultural and spiritual elements, and it can be considered under the following headings.

Predisposing factors

These are long-term issues that have shaped the patient's life. General practitioners (GPs) might consider family history of mental illness; personality issues; social context, such as long-term and intergenerational unemployment; and interpersonal history, including trauma.

Precipitating factors

These are subacute factors that drive the current presentation. GPs might consider recent issues, such as physical illness, medication side effects, substance abuse, life events and stressors, workplace issues, discrimination or harassment and social circumstances.

Perpetuating factors

These factors are ongoing and may need to be addressed in psychological therapy or through other psychosocial interventions, such as financial support or housing. GPs might consider chronic illness, relationship issues, responsibilities for children or aged relatives, loneliness, financial problems and unstable housing.

Protective factors

It is important to consider a person's strengths, as well as their challenges, and it can be helpful to discuss situations in which the patient has managed well in the past. GPs might consider ongoing treatment, existing coping skills, personality traits, social connections and a sense of meaning and purpose.

should be modified to be a more 'believable patient' to the clinician. Choosing between diagnoses requires actively and consciously questioning how the patient's (and the clinician's) cultural identity factors into their presentation and their diagnosis.

If GPs create a good formulation with patients, then GPs can assist patients towards their own recovery.[43] Patients need to make sense of their experiences and accept and value the learning they gain from managing adversity to take ownership of their recovery. In this way, GPs can help patients shift from passively receiving care to instigating growth.[44] A good diagnosis is negotiated and shared, until ideally the GP and patient come to a common understanding of 'what is going on'. This lays the groundwork for a shared management plan.

For Aditya, the risk of trauma is high given his parents' history of conflict. There is also a risk that he may be experiencing cross-cultural issues at school. Ultimately, the GP must decide how Aditya's sociocultural context is shaping his presentation, and what role internal and external factors play in his presentation. The GP's understanding of context will guide the choice of therapy for Aditya and his family.

Ethics: The helpful diagnosis

A clinician's role is not to make an accurate scientific classification but to improve a person's health and wellbeing.[1] Therefore, GPs need to choose diagnoses that are helpful, not just accurate. Psychiatric diagnosis carries considerable ethical weight: it can rationalise a person's unusual behaviour, enable access to services and make sense of a bewildering range of symptoms, enabling patients to pursue their own recovery.[45] However, declaring someone 'ill' or 'disordered' leverages considerable social power, including the power to restrict liberty, so diagnosis can also cause harm.[1,46,47] The ethical principles behind diagnosis are summarised in Box 4.

Although GPs may be reticent to issue a diagnosis for fear of further contributing to stigma, summarily withholding diagnosis for a marginalised patient can constitute a barrier to access for essential supports. It is therefore crucial to discuss the diagnostic decision with the patient and explicitly reflect on the way that external factors may interact with the patient's experience. These discussions present an opportunity for patients to explain their cultural and personal position regarding the utility and implications of a diagnosis, and enables clinicians to negotiate with the patient why a particular diagnosis might be useful or helpful.

Diagnosis focuses on pathologies and weaknesses, yet recovery is strengths based.[44] Many individuals have described being defined by their diagnostic category[48] and have experienced long periods of illness before making meaning of underlying trauma.[49] An imbalance between scientific classification and a thorough formulation of a person's mental health can be deeply harmful. Being misdiagnosed with a disorder can lead to iatrogenic harm from inappropriate treatments, but it can also preclude access to more helpful interventions, such as trauma-focused care.[50]

A diagnostic label can affect a person's career, impede physical healthcare because of diagnostic overshadowing, and have an impact on their social life. It can also cause deep harm to a person's sense of self because of the unfortunate reality of stigma and discrimination. Therefore, diagnosis always has an ethical dimension. GPs will care for patients who have experienced considerable harm from misdiagnosis, and they can play a critical role in establishing a good therapeutic alliance.

One consumer, Inigo Daya, writes about her experience where diagnostic harm outweighed benefit.[51] For her, recovery began when she was able to address the trauma that underpinned her illness. Prior to that understanding, she had experienced involuntary hospitalisation, multiple medications and electroconvulsive therapy, each treatment associated with significant iatrogenic harm. She notes that the biggest cost was the threat to her identity and agency, describing a sense of hopelessness as she adapted to a future with chronic

Box 3. Understanding bias: Is mental health assessment and management really based on objective criteria?

Garb[41] performed a meta-analysis of studies examining social expectations and stereotypes (eg racial bias, social class bias and gender bias) in clinical judgment and found trends for bias in some specific tasks but not others. Most studies presented clinicians with written vignettes, manipulating only the social characteristics (ie their ethnicity, gender or socioeconomic status). The difference in clinical judgment between conditions indicates potential bias that cannot be accounted for by differences in cultural expression. The following clinical decisions were affected.

Socioeconomic status influences

- Prognostic ratings
- Referral for psychotherapy
- Use of supportive psychotherapy versus insight-oriented therapy
- Referral of children to specialty schools for learning disability
- Referral for suspected child abuse

Ethnicity influences

- Decision to treat affective symptoms
- Prescription of antipsychotics
- Diagnosis of schizophrenia, bipolar affective disorder
- Estimated risk of violence in hospitals or prisons
- Predicted likelihood of rehospitalisation
- Severity of rated psychopathology
- Referral for suspected child abuse
- Psychologist rating of passivity, social poise, capability of maintaining relationships

treatment-resistant mental illness. Her story emphasises the importance of formulations and the dangers of premature closure.

For Aditya, there are significant ethical concerns. The GP must make a psychiatric classification that has merit and integrity: the diagnosis should be accurate. Coupled with this is the issue of justice. Aditya's GP may not share his cultural context, and this can create challenges in understanding his needs and providing culturally appropriate care. This needs to be carefully managed. The benefits of the diagnosis – including access to services, treatments and support – must outweigh the harms. Harms in this case include changes to his identity if Aditya sees himself as 'disordered' at such a young age, as he is likely to experience discrimination and stigma. There is also a harm in seeing Aditya as the problem rather than understanding that he is part of a dysfunctional family system. A good formulation may be helpful if the GP is able to acknowledge any trauma Aditya has experienced growing up in a high-conflict home. By acknowledging this background, the GP may be able to support Aditya's growing autonomy, helping him to develop strategies to manage his distress and enhance his own agency.

Conclusion

Psychiatric diagnosis is not a simple act of classification. As Sadler would say, we are not botanists.[1] The GP's job as a clinician is to behave more like a gardener: understanding botany, but focusing on applying their skills to nurture and support the health of their patients within their rich contexts. To do so, the GP's diagnosis must be accurate, comprehensive and helpful. GPs have a responsibility to make their diagnosis as complete and clinically useful as possible, and that involves systematically exploring the science, art and ethics of mental illness experience.

Box 4. Ethical principles in psychiatric diagnosis[54]

There is a framework of moral principles that underpin mental health practice, including diagnosis.

Autonomy

Respect for autonomy recognises that patients have their own views, capacities and perspectives, and they have a right to exercise that autonomy by making informed decisions. When making a diagnosis, it is important to recognise these perspectives by listening carefully to a person's story, incorporating their perspectives within the formulation where possible, and managing disagreements respectfully. Psychiatry is unique in that it can restrict personal liberty. General practitioners need to manage the fear of loss of autonomy thoughtfully and support the patient when restriction of liberty is required (eg with high-risk suicidality).

Non-maleficence

This principle extends the maxim 'first do no harm' and may override principles of autonomy. Harm can include misdiagnosis, leading to inappropriate treatment, so this principle includes the need to diagnose safely and accurately. However, there are also harms related to all mental health diagnoses. Unfortunately, mental health diagnoses carry stigma and discrimination that can have a profound impact on a person's life. It could be argued that a diagnosis should not be made if the harm outweighs the benefit, and this is particularly relevant when patients are on the border between wellness and illness, or when patients are children.

Beneficence

The welfare of patients is the primary goal of medicine, so diagnosis should be beneficial. The principle of autonomy suggests patients should be engaged in deciding on potential benefits and harms in collaboration with their treating team. This principle is particularly important with children: sometimes the benefit is received by others (eg funding for learning support at school benefits parents and teachers) and the long-term harm may be less visible (stigma and poor self-concept for the child), so the potential benefits and harms need to be carefully balanced.

Justice

There should be fair, equitable and appropriate distribution of services across the population, which means people in marginalised communities should have access to the same benefits and no additional harms when compared with the general population. As shown in Box 3, benefits and harms are not equally distributed. Overdiagnosis and underdiagnosis are both harmful. Where possible, transcultural performance as diagnosticians should be improved by using appropriate resources, including interpreters and cultural informants.

Authors

Louise Stone MBBS, BA, DipRACOG, GDFamMed, MPH, MQHR, PhD, FRACGP, FACRRM, Clinical Associate Professor, Academic Unit of General Practice, ANU Medical School, Australian National University, ACT. dr.louise.stone@gmail.com

Elizabeth Waldron, Flinders University, SA

Heather Nowak DipCSMH, Consumer representative, National Mental Health Consumer and Carer Forum, ACT

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correspondence **ajgp@racgp.org.au**