‘That red flag on your file’:

Misinterpreting physical symptoms as mental illness

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Abstract

Aims and objectives: To ascertain the views and experiences of mental health consumers regarding the availability and quality of care and treatment received for their physical health needs.

Background. People diagnosed with mental illness have higher occurrence of physical health problems. Responsive health care services are crucial for prevention and management of physical health problems, and for reducing disparities in health between people diagnosed with mental illness and those who are not. There is limited research giving voice to consumer perspectives on their experiences with health care providers.

Design. Exploratory qualitative.

Methods. Focus group interviews with mental health consumers accessed via a consumer network group in a region of Australia (n=31). All interview audio recordings were transcribed professionally. Interviews were thematically analysed.

Results: The main themes were: symptomising; failure to act; and alertness to prejudice. The first two themes were consumer perceptions of the actions and behaviours of health professionals, and the third describes consumer responses to these behaviours and actions. Consumers described increased risks of illness and death because of undiagnosed physical illness despite their physical health advice-seeking as the reason for the health consultation.

Conclusion. Health care providers' non-recognition of physical health problems presents a clear example of a significant and potentially life threatening health inequity. The service provider responses described by participants suggest mental health consumers' physical health needs may not be taken seriously.

Relevance to clinical practice. Clinicians need to take seriously the physical health needs and concerns of people with mental illness. Nurses can play a crucial role in the prevention of diagnostic overshadowing as part of a broader direction of balancing biomedical perspectives with other approaches to health care.

KEYWORDS

Consumer participation

Diagnostic overshadowing

Health care access

Mental Health Nursing

Mental health services

Physical Health

Stigma

What does this paper contribute to the wider global clinical community

- Despite increased awareness of physical health care inequities for people with mental illness, physical illness is often undiagnosed because physical symptoms are interpreted as indicative of mental illness.
- Lack of response to physical health concerns discourages consumers from engaging with health services, resulting in further physical health deterioration.
- Diagnostic overshadowing can be a life-and-death matter for mental health consumers and this discriminatory practice has to be much more assertively addressed.
- Perspectives and experiences of mental health consumers must be fundamental to research activities and practice change.

Introduction

The international literature provides conclusive evidence that the life expectancy of people diagnosed with mental illness is between 10 and 32 years less than the general population (Colton & Manderscheid 2006, Laursen

et al. 2014, O'Donoghue *et al.* 2014). The causes of premature death are primarily preventable illnesses such as cardiovascular disease (Holt 2015, Lawrence *et al.* 2013). Strikingly, though health care service provision is vital to addressing these disparities, shortfalls between access to physical health care and physical health needs of people with mental illness are frequently reported (Connolly *et al.* 2015, De Hert *et al.* 2011a, Scott & Happell 2012). Understanding the experiences and opinions of mental health consumers about physical health care is crucial to understanding the nature of these disparities, yet a shortage of primary research articulating the consumer voice is apparent (Chadwick *et al.* 2012). The current study gives voice to the views and experiences of mental health consumers regarding the care and treatment received from health care providers in relation to their physical health needs.

Background

There are several potential causes of the significant physical health disparities between people with and without mental illness, such as socio-economic deprivation (Robson & Gray 2007), smoking (Bartlem *et al.* 2015, Laursen *et al.* 2014, Scott & Happell 2011), poor diet (Barre *et al.* 2011, Chacón *et al.* 2011), drug and alcohol misuse (Morgan *et al.* 2013, Scott & Happell 2011), inadequate physical activity (Krogh *et al.* 2014, Vancampfort *et al.* 2012); and psychiatric medications (Choong *et al.* 2012, Waterreus *et al.* 2012, Weissman *et al.* 2012). Health care services are central to physical illness prevention and management of physical illnesses for people with mental illness (Holt 2015, Viron *et al.* 2012), yet under screening of preventable illnesses remains a major issue (Connolly *et al.* 2015, Howard *et al.* 2010).

To address the health care gaps, integrated care models or interventions focused on physical health are emerging, including improved screening, assessments, referral rates and completed referrals (Druss & von

Esenwein 2006, Druss *et al.* 2010, White *et al.* 2011), co-locating physical and mental health services (Pirraglia *et al.* 2012), collaborative care facilitation such as peer navigators (Kelly *et al.* 2014), and health-behaviour change and maintenance (Bruins *et al.* 2014, Fernandez-San-Martin *et al.* 2014, Wardig *et al.* 2016). However, much more integrated health care is needed to tackle the disparities in physical health between people with and without mental illness (Moore *et al.* 2015).

One factor which is receiving increasing attention in the physical health disparities impacting people with mental illness is diagnostic overshadowing, where a service users physical symptoms are attributed to their mental illness (Nash 2013). Diagnostic overshadowing has been recognised as a particular type of misdiagnosis impeding access to the physical health care needs of people with mental illness (Thornicroft 2011). This may result in delayed diagnosis and treatment of physical health conditions, leading to worsening of the consumers mental health (Nash, 2013). Diagnostic overshadowing is problematic whenever there is more than one illness, where the presence of one may lead to non-recognition of another (Wood & Tracey 2009). This problem is well recognised in health care. Provider-level surveys of doctors (Graber *et al.* 2000) and nurses (McDonald *et al.* 2003) demonstrate how healthcare professionals attitudes toward physical symptoms are manipulated by knowledge of psychiatric illness or use of psychotropic medication.

Critically, the problem of diagnostic overshadowing extends to emergency medical care. In a study of 25 emergency medicine professionals, factors such as clinicians attitudes towards mental illness, and difficulties in working with mental health services to achieve emergency discharge targets were identified as contributors to diagnostic overshadowing (Van Nieuwenhuizen *et al.* 2013). More recently, Shefer and colleagues (2014) explored cases of diagnostic overshadowing at four

London-based hospital emergency departments. The authors surmised that unclear staff roles and responsibilities, pressures of the health care environment, “challenging behaviour” of consumers and stigma “held by a minority of staff” were potential causes of diagnostic overshadowing. While Shefer *et al.* (2014) inquired into the views of health care providers, diagnostic overshadowing is also reported by mental health consumers in the UK (Lester & Tritter 2005), Canada (Clarke *et al.* 2007) and Australia (Mental Health Council of Australia 2005).

Qualitative studies of consumer perspectives of physical health care have reported experiences suggestive of diagnostic overshadowing (Gonzalez-Torres *et al.* 2007, National Alliance on Mental Illness (NAMI) 2008), with one large-scale survey of mental health consumers reporting almost half believed their physical health concerns were overlooked when a psychiatric diagnosis became known (National Alliance on Mental Illness (NAMI) 2008). To address this emergent contributor to the disparity in physical health care experience by mental health consumers, an increased understanding is required from their perspective. Consumers' first-hand experience is crucial in research of health care provider behaviour, such as apprising how effectively health care is provided and how it can be improved (Chadwick *et al.* 2012, Cranwell *et al.* 2016, McCloughen *et al.* 2016).

Methods

Aim

Addressing the disparity in physical health care between people diagnosed with a mental illness and the general population requires consumer-driven solutions. Consumers are therefore key stakeholders in the physical health research agenda. The aim of the current research project was to articulate consumers' perceptions and experiences regarding the

availability and quality of care and treatment provided in response to physical health needs and issues.

Design

Qualitative exploratory methods described by Stebbens (2001) were employed for this study. Qualitative exploratory research are designed to facilitate thorough investigation of a topic or issue from the perspective of those participants best able to inform the research question, in this case consumers of mental health services. Qualitative exploratory approaches are therefore highly suitable to examine issues that have not been thoroughly researched, and providing voice to who are frequently not heard in research and decision making arenas.

Setting

The research was conducted in the ACT. The ACT Mental Health Consumer Network (ACTMHCN), the peak body for mental health consumers in the region fully endorsed and supported the research.

Participants

Target participants were people who self-identified as consumers of mental health services and had an interest in physical health issues. The project was advertised in the weekly bulletin distributed to members of the ACTMHCN. Consumers were invited to contact the research team for more information and participant Information sheets and consent forms were provided to those who expressed interest in contributing to the study. The ACTMHCN enrolled those who expressed interest in one of four focus groups.

Names and any other potentially identifying information was kept confidential by ACTMHCN. Thirty-one consumers participated, with focus groups ranging from seven to nine participants per group. Payment of \$75 per interview provided to consumers was commensurate with the policies of the ACTMHCN and reflects best practice in reimbursing consumers for their expertise.

Data collection

Interviews were held at the premises of ACTMHCN because it was centrally located and easily accessed by public transport and was a familiar venue for many participants. It also demonstrated the organisation's support for this research, and therefore enhanced its credibility. Focus groups were conducted by two researchers with substantial expertise in focus groups methods, specifically in conducting focus groups with mental health consumers. Furthermore, as a result of previous experience in advocacy, academic, research and lived experience perspectives, the researchers conducting the focus groups were very familiar with physical health issues effecting consumers. For example, one researcher had a mental health nursing research background and the other a consumer researcher background. Including consumer researchers as part of the research team, and in conducting focus groups is consistent with enhancing consumer participation in mental health research to ensure it authenticity and relevance (Shippee *et al.* 2015). The team also believe consumer participants may feel more comfortable to express their views and experiences openly which they may not have been comfortable to do with only a health professional researcher present.

Prior to the interviews, a guide was co-developed by the researchers. While specific issues were reflected in the questions, they were kept very broad to encourage participants to describe their opinions and experiences

freely and without the barriers of pre-conceived and highly focused questions.

At the beginning of each interview, the researchers introduced themselves and provided a brief overview of their backgrounds and expertise in relation to the research. Duration of focus groups ranged between 90 and 150 minutes. The focus groups were audio recorded to provide an accurate record for transcription.

Ethical considerations

The research received ethical approval from the University of Canberra Human Research Ethics Committees prior to study commencement. A signed consent form was requested from study participants before each interview began. A brief outline of the study, reflecting the content of the plain language statement, was provided verbally at the commencement of each interview. Participants were provided the opportunity to ask any questions or seek further clarification.

Issues of privacy and confidentiality were discussed and participants were assured these would be protected, and specifically that no identifying information including names of people or health services would be published. Participants were also asked not to disclose any discussions from the focus group to external parties. The researchers sought permission from participants to audio record the interviews to enable a complete and accurate interview transcript to be produced. All participants consented to audio recording of the focus groups.

Analysis

Interviews were transcribed verbatim by a professional external transcribing service and full accounts of the four focus groups were

produced. Data were analysed separately and independently by two members of the research team. A thematic analysis approach was taken based on the framework developed by Braun and Clarke (2006). This framework consists of five stages. In the initial stage researchers read and re-read the transcripts several times to become familiar with the contents. Stage 2 encompassed identifying and manually coded specific content. The codes were reviewed and grouped according to similarity of content. During stage 3, tentative themes were identified and provisionally labelled. Stage 4 involved the creation of a conceptual map of tentative themes. In the final stage, the conceptual map and themes were rechecked for accuracy and to ensure all important information was extracted from the transcripts. The thematic structure was reviewed by all team members and adjusted until consensus was reached.

Rigour

The credibility of the research was enhanced through prolonged engagement. Two hours was made available for interviews to allow sufficient time for participants to feel comfortable to express themselves freely (Horsfall *et al.* 2007). Ensuring the methodological processes were rigorous was facilitated through the use of code reliability (Rice & Ezzy 2005), following the independent process of analysis described in the previous section.

Findings

Three themes emerged from analysis of the transcripts: *Symptomising by provider*, *Failure to act by provider* and *Consumer Alertness to prejudice*. Quotes from the focus group interviews are provided below to illustrate some

of the findings reported, the number of the focus group (FG) from which the quote was taken is included.

Symptomising by provider

In all focus groups, participants described by which health care providers attributed physical symptoms to the consumers mental illness, without consideration of a possible physical illness:

...they dismiss physical health concerns as part of your mental illness....This is really, really common. (FG3)

Symptomising included the apparent perception by providers that the consumer was 'crazy', and therefore their expressions of physical illness were fictitious because consumers were lacking in insight and competence and therefore unable to separate their physical symptoms from their mental state. For instance, one participant reflected on a visible physical symptom that had been of concern for a long time, but could not get much progress on a diagnosis. The participant considered providers to have avoided a serious effort at diagnosis:

I got back sensation I lost when I hit – missed the pool, and sensation I lost when I got the nerves coming back here. So is that a mental health condition or is that a physical health condition? Because every time I go to a doctor about it, for 15 years, they'd say, oh, that didn't happen; you went crazy, darling. So a lot of what is diagnosed as mental health is actually a physical health problem that they've chosen not to understand. (FG1).

Having been diagnosed or recorded as having mental illness was frequently described as framing the whole relationship between consumer

and provider, with the providers interpreting any concerns or symptoms as symptoms of the mental health diagnosis. Behaviours or responses by the consumer could not transcend the provider's outlook:

...no matter how you, you know, well you are, no matter how much, how good you seem and how well spoken you are and all those sorts of things, you just get treated like a complete nut case. (FG3)

When participants described physical health problems, clinicians often made no effort to check or investigate further. The word "belief" came up regularly in focus group discussions. Often this referred to scenarios where providers questioned or ignored the presence of a physical illness. Consumers were often uncertain themselves if the issue was physical and hence the whole point of consulting a medical expert was to clarify the health problem. What struck them was the difficulty in getting an assessment or screening that would be straightforward to attain if there were no mental illness label:

...what I think of physical health in relation to mental health, is physical health is the symptoms I am treating and seeking treatment of when I get accused of being mentally ill [sic]. (FG1)

The underlying current through the narratives of participants was the sense that the health care provider saw them as lacking insight and competence. This resulted directly from the diagnosis or recording of mental illness, where providers tended to automatically assume consumers did not have insight into their own health, even when they held positions of importance and authority within the mental health community:

...I was the chair of the network – this network [major mental health consumer network], and I'd go to a doctor and they'd still say, oh, you

obviously don't know that you're mentally ill [sic] And respond as if I was completely clueless. (FG1)

There were consistent descriptions provided of derogatory responses of medical providers to consumers, where lack of health literacy was implied and imputed simply based on the consumer's diagnosis:

...you can't also possibly be health literate if you have chronic and complex mental health issues. (FG1)

Even when participants wanted to take on greater responsibility for their own health, such as self-care, this too was interpreted in terms of mental illness:

....if you then try and incorporate your knowledge into yourself care you'll say – “oh, no, you're crazy” – and they'll actually use your efforts towards care as indication of greater illness. (FG1)

Not believing what consumers would say during consultations was interpreted as indicative of a broader lack of trust on the part of providers. Participants clearly valued having a relationship with a doctor based on trust, but this would be lost over time:

...another year they started medication ... I had very bad side effects. And [they sent] me to doctors ... to specialists and they even gave it [the medication] to me again...I deteriorated mentally with hopelessness and physically and with all this trust which is important with your doctors ... he treated me very badly that I'm making up story and things like that. (FG3)

As a further example of the spreading of the mental illness symptomising in a family context, the parenting performance of consumers was questioned by providers, such as physical health problems of the child of a consumer, where the imputation that the mother harmed the child as the real reason for the child's physical health problem:

I've definitely had people tell me stories about being mums and not only are they not only believed about their own health, it impacts on the child. The kid's knee swelled up like this when she just played ... half an hour of softball and they're going, "Oh yeah, is it? What have you done to her knee?" (FG3).

Failure to act by provider

As health care providers were viewed as dismissive of consumer concerns, the result was reluctance or failure to act by the provider. As participants conveyed in the focus groups, having physical symptoms viewed correctly and accurately by providers was not just appropriate professional conduct, but a decision of life and death in some instances. When physical health needs were not addressed, as frequently occurred, consumers were vulnerable to worsened health and in several cases, high risk of early death. To make the case, participants relayed many examples of inadequate physical health care. One participant describes awareness of these situations from a professional capacity:

This is actually the most common complaint that we hear from members ... A few years ago we had a member of ours die of a heart condition because the doctor dismissed his symptoms as part of his mental illness. They said it was just anxiety. So it went undiagnosed. (FG3)

Although more provision of medication would look like an action by a provider, participants saw the continual reliance on medication as failure or a static response to any problem the consumer would raise:

... another member...she went two years going to doctors here about fainting spells and that sort of thing. They kept upping her medication, her psychotropic medication. Went up to Sydney. When she was in Sydney went to the hospital there because she had a fainting spell, was diagnosed with diabetes. So they just completely disregarded. (FG3)

Besides medication, referring the consumer to another provider of mental health services would be another pathway that also did not address physical health issues raised by the consumer:

I had a friend who actually went to a doctor about a groin injury and she just said, "Oh, it's just in your head, you need to see a psychologist." "Well, no, I'm pretty sure it's hurting there and I didn't have this problem before I did this exercise," and she said, "No, just go to a psychologist." Well, no, you want to be fully convinced that you're okay physically before you go to see a psychologist. (FG4)

Consumer alertness to prejudice

Consumers had heightened attention to how health care providers interpreted and responded to their concerns. As the providers tended to interpret all complaints as symptoms of the mental illness diagnosis, they were unlikely to respond appropriately. Consumers felt very vulnerable in terms of their physical health, and by implication, were more alert to prejudice in the health care system. Most focus groups demonstrated a shared vigilance towards stigma and prejudice which was not confined to any particular mental illness:

....it doesn't just happen to the people who have, sort of, more visible mental illness like severe schizophrenia or something like that. It happens to everybody. The second you've got that red flag on your file.... That's why we've got to get rid of it, the stigma or whatever it is that's holding us down (FG3).

For one participant, the challenge was to avoid particular labels, in this case – hypochondria. The participant wanted assurance that an elbow injury was not serious, but the mental health diagnosis was a barrier to getting the elbow assessed:

I'm just really afraid of getting labelled a hypochondriac, which I think I am, but I think it's very stigmatised... a lot of mental illness is stigmatised, but I think that's one that's particularly stigmatised because I have this thing where I – every little sore or injury I get, I get so anxious that it's going to last forever and it's a such big deal and early on when I started having this problem I went to a doctor about it and she said - I had a blood test and my elbow kept hurting for a long time afterwards, for months. I said, "Oh, I think it's from the blood test." She said, "Oh, well, that's the weirdest thing I've ever heard." And she didn't look into it any further and I just think no matter what the injury is and how convinced they are that it's just psychological, they should look into it completely to give you peace of mind... (FG4)

Discussion

The findings from this research suggest when consumers seek assistance for physical health concerns, their symptoms are often interpreted as reflecting their mental health rather than a physical health issue. This is despite the well-known higher occurrence of serious physical health problems

experienced by people diagnosed with mental illness (De Hert *et al.* 2011b, Laursen *et al.* 2014).

Perceptions that all health problems described by people with mental illness are in fact not physical in nature, has been found to lead to biased judgements including the discounting of a person's genuine inquiries into the presence of physical illness. This form of clinical error, often referred to as 'diagnostic overshadowing' (Jones *et al.* 2008) poses a major impediment for mental health consumers when seeking treatment that should be readily available to all. The stories voiced in this study reaffirm the existence and detrimental impact of diagnostic reasoning, found previously across Australia and internationally, from the viewpoints of mental health consumers but also health care providers, carers and Non-Government Organisations (McCabe & Leas 2008, Mental Health Council of Australia 2005, Shefer *et al.* 2014). Furthermore, diagnostic overshadowing may be a major mechanism in what has been regularly reported on disparities in health care – namely, under-diagnosis and under-treatment of physical health problems of people with mental illness (Connolly *et al.* 2015, Lawrence & Coghlan 2002).

The first two themes that emerged from the current analysis: *symptomising by provider* and *failure of provider to act*, clearly reflect stigmatisation by health providers. Thornicroft *et al.* (2007) state that stigma encompasses "problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination) (p. 192)." Participants did not refer to lack of knowledge by health care providers, however prejudice and discrimination were directly referred to. It is well recognised in the literature that mental health consumers see themselves as subject to discrimination and stigma within the mental health sector (Gonzales *et al.* 2014, Green *et al.* 2003). A literature review of qualitative studies of consumers receiving community mental health services confirms that prejudice and discrimination are features of stigma (Mestdagh & Hansen

2014). Furthermore, negative attitudes of health professionals in the general health care system has been identified (Knaak *et al.* 2015, Noblett *et al.* 2015).

The current findings highlight the influence of diagnostic overshadowing in determining whether physical health care is properly addressed when actively requested by mental health consumers. Participants provided numerous examples of health providers' neglect and negative attitudes. These "problems of behaviour" as described (Thornicroft *et al.*, 2007, p. 192), are clear examples of discrimination. Mental health consumers saw the denial of treatment for physical health issues as a failure on the part of the provider to respond in a professional way to consumer's concerns. Professional behaviour would involve assessing and if necessary treating the potential physical health problem in the same way as if the person did not have a diagnosis of mental illness.

Through these negative experiences of physical health concerns being rejected or downplayed by health care providers, consumers became vigilant to avoid being stigmatised and further subject to prejudice by the health care system. Efforts to avoid stigma diminish the likelihood that mental health consumers engage with the health care system (Dixon *et al.* 2016, Procter *et al.* 2015a, Procter *et al.* 2015b). The significance of this finding needs to be emphasised, given the principle of close consumer-provider relationships and consumer-oriented services in best practice and policy (Australian Government 2012, British Medical Association 2014, Department of Health and Ageing 2013).

Diagnostic overshadowing is recognised as a significant barrier to mental health consumers gaining physical health care, and therefore a major barrier to reducing the life expectancy inequities for people with mental illness. Decisive strategies to prevent or minimise the risk of this

practice need to be actioned in research, policy and practice. For example, based on the finding of Shefer et al. (2015), along with input from agencies advocating for the improved delivery of physical health services for mental health consumers, specific recommendations to improve the diagnosis process will be proposed. Whether this leads to a reduction in diagnostic overshadowing remain to be seen. However it may offer a useful beginning point for mental health services. Experimental research has provided preliminary evidence that risk of diagnostic overshadowing can be reduced by educating clinicians about these types of clinical errors (Wood & Tracey 2009). Training and education may reduce diagnostic overshadowing (Shefer et al. 2015), however this is less likely if negative attitudes from health professionals towards mental health consumers remain.

Limitations

The qualitative nature of this study does not support generalizability beyond the participants from one Australian region. Clearly there is need for more research on mental health consumer experience of diagnostic overshadowing in broader populations from more diverse settings.

Conclusions

Consumers of mental health services have the right to receive high quality health care for both physical and mental health conditions. The now well-documented life expectancy gap is evidence that this is not common practice. Reducing the gap requires a concerted effort to understanding the reasons this inequity persists. Diagnostic overshadowing must be recognised as a possible contributing factor, and therefore an issue to be addressed if viable solutions are to be found. Mental health consumers participating in this research recognised prejudicial attitudes as common practice when physical health concerns were interpreted as symptoms of

mental illness. These interpretations of their experiences with providers in both primary care and mental health care lead to heightened vigilance for further prejudice, and a higher likelihood consumers will disengage with the health care system. As a consequence, consumer's risk not receiving much-needed physical health care. Diagnostic overshadowing is a discriminatory practice that has to be much more assertively addressed by all health professions. Nurses can play a major role by taking consumers' concerns seriously and advocating for improved, accessible and non-judgemental physical health care.

Implications for clinical practice

Clinicians in all health care services need to be knowledgeable about the risk of physical illness for people diagnosed with mental illness, and the contribution of diagnostic overshadowing to worsening physical health. Nurses are well positioned to play a crucial role in highlighting the issue of diagnostic overshadowing, a problem that must be overcome to substantively improve access to quality physical health care. For example a specialist nursing role in physical health care has been suggested (Happell *et al.* 2014) to facilitate co-ordination of physical health services of mental health consumers. The physical health nurse consultant should be explored as a promising avenue to reduce diagnostic overshadowing and its impacts via education of health care colleagues and supporting collaborative care between mental and physical health specialists.

References

Australian Government (2012) The roadmap for national mental health reform 2012-2022. Commonwealth of Australia, Canberra.

Barre LK, Ferron JC, Davis KE & Whitley R (2011): Healthy eating in persons with serious mental illnesses: understanding and barriers. *Psychiatric Rehabilitation Journal* **34**, 304-310.

Bartlem KM, Bowman JA, Bailey JM, Freund M, Wye PM, Lecathelinais C, McElwaine KM, Campbell EM, Gillham KE & Wiggers JH (2015): Chronic disease health risk behaviours amongst people with a mental illness. *Australian and New Zealand Journal of Psychiatry* **49**, 731-741.

Braun V & Clarke V (2006): Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**, 77-101.

British Medical Association (2014) Recognising the importance of physical health in mental health and intellectual disability: achieving parity in outcomes.

Bruins J, Jorg F, Bruggeman R, Slooff C, Corpeleijn E & Pijnenborg M (2014): The effects of lifestyle interventions on (long-term) weight management, cardiometabolic risk and depressive symptoms in people with psychotic disorders: a meta-analysis. *PLoS One* **9**, e112276.

Chacón F, Mora F, Gervás-Ríos A & Gilaberte I (2011): Efficacy of lifestyle interventions in physical health management of patients with severe mental illness. *Annals of General Psychiatry* **10**, 22.

Chadwick A, Street C, McAndrew S & Deacon M (2012): Minding our own bodies: Reviewing the literature regarding the perceptions of service users diagnosed with serious mental illness on barriers to accessing physical health care. *Int J Ment Health Nurs* **21**, 211-219.

- Choong E, Bondolfi G, Etter M, Jermann F, Aubry JM, Bartolomei J, Gholam-Rezaee M & Eap CB (2012): Psychotropic drug-induced weight gain and other metabolic complications in a swiss psychiatric population. *Journal of Psychiatric Research* **46**, 540-548.
- Clarke DE, Dusome D & Hughes L (2007): Emergency department from the mental health client's perspective. *Int J Ment Health Nurs* **16**, 126-131.
- Colton C & Manderscheid R (2006): Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease* **3**, 1-14.
- Connolly JG, Toomey TJ & Schneeweiss MC (2015): Metabolic monitoring for youths initiating use of second-generation antipsychotics, 2003-2011. *Psychiatric Services* **66**, 604-609.
- Cranwell K, Polacsek M & McCann TV (2016): Mental health consumers' with medical co-morbidity experience of the transition through tertiary medical services to primary care. *Int J Ment Health Nurs*.
- De Hert M, Cohen DAN, Bobes J, Cetkovich-Bakmas M, Leucht S, Ndeti DM, Newcomer JW, Uwakwe R, Asai I, Möller H-J, Gautam S, Detraux J & Correll CU (2011a): Physical illness in patients with severe mental disorders. II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level. *World Psychiatry* **10**, 138-151.
- De Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, Detraux J, Gautam S, Moller HJ, Ndeti DM, Newcomer JW, Uwakwe R & Leucht S (2011b): Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry* **10**, 52-77.

Department of Health and Ageing (2013) A national framework for recovery-oriented mental health services: Policy and theory. Commonwealth of Australia, Canberra.

Dixon LB, Holoshitz Y & Nossel I (2016): Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry* **15**, 13-20.

Druss BG & von Esenwein SA (2006): Improving general medical care for persons with mental and addictive disorders: systematic review. *General Hospital Psychiatry* **28**, 145-153.

Druss BG, von Esenwein SA, Compton MT, Rask KJ, Zhao L & Parker RM (2010): A randomized trial of medical care management for community mental health settings: the Primary Care Access, Referral, and Evaluation (PCARE) study. *American Journal of Psychiatry* **167**, 151-159.

Fernandez-San-Martin MI, Martin-Lopez LM, Masa-Font R, Olona-Tabuena N, Roman Y, Martin-Royo J, Oller-Canet S, Gonzalez-Tejon S, San-Emeterio L, Barroso-Garcia A, Vinas-Cabrera L & Flores-Mateo G (2014): The effectiveness of lifestyle interventions to reduce cardiovascular risk in patients with severe mental disorders: meta-analysis of intervention studies. *Community Ment Health J* **50**, 81-95.

Gonzales L, Davidoff KC, Nadal KL & Yanos PT (2014): Microaggressions Experienced by Persons With Mental Illnesses: An Exploratory Study. *Psychiatric Rehabilitation Journal*.

Gonzalez-Torres MA, Oraa R, Aristegui M, Fernandez-Rivas A & Guimon J (2007): Stigma and discrimination towards people with schizophrenia and their family members. A qualitative study with focus groups. *Social Psychiatry Psychiatric Epidemiology* **42**, 14-23.

- Graber MA, Bergus G, Dawson JD, Wood GB, Levy BT & Levin I (2000): Effect of a patient's psychiatric history on physicians' estimation of probability of disease. *Journal of general internal medicine* **15**, 204-206.
- Green G, Hayes C, Dickinson D, Whittaker A & Gilheany B (2003): A mental health service users perspective to stigmatisation. *Journal of Mental Health* **12**, 223-234.
- Happell B, Stanton R & Scott D (2014): Utilization of a cardiometabolic health nurse – a novel strategy to manage comorbid physical and mental illness. *Journal of Comorbidity* **4**, 22-28.
- Holt RI (2015): The prevention of diabetes and cardiovascular disease in people with schizophrenia. *Acta Psychiatrica Scandinavica* (in press).
- Howard L, Barley E, Davies E, Rigg A, Lempp H, Rose D, Taylor D & Thornicroft G (2010): Cancer diagnosis in people with severe mental illness: practical and ethical issues. *Lancet Oncology* **11**, 797.
- Horsfall J, Cleary M, Walter G & Hunt GE (2007): Conducting mental health research: Key steps, practicalities, and issues for the early career researcher. *International Journal of Mental Health Nursing* **16**, S1-S20.
- Jones S, Howard L & Thornicroft G (2008): 'Diagnostic overshadowing': worse physical health care for people with mental illness. *Acta Psychiatrica Scandinavica* **118**, 169-171.
- Kelly E, Fulginiti A, Pahwa R, Tallen L, Duan L & Brekke JS (2014): A pilot test of a peer navigator intervention for improving the health of individuals with serious mental illness. *Community Ment Health J* **50**, 435-446.

Knaak S, Patten S & Ungar T (2015): Mental illness stigma as a quality-of-care problem. *The Lancet Psychiatry* **2**, 863-864.

Krogh J, Speyer H, Norgaard HC, Moltke A & Nordentoft M (2014): Can exercise increase fitness and reduce weight in patients with schizophrenia and depression? *Frontiers in Psychiatry* **5**, 89.

Laursen TM, Nordentoft M & Mortensen PB (2014): Excess early mortality in schizophrenia. *Annual Review of Clinical Psychology* **10**, 425-448.

Lawrence D & Coghlan R (2002): Health inequalities and the health needs of people with mental illness. *NSW Public Health Bulletin* **13**, 155-158.

Lawrence D, Hancock KJ & Kisely S (2013): The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. *British Medical Journal* **346**, 2539.

Lester H & Tritter JQ (2005): 'Listen to my madness': understanding the experiences of people with serious mental illness. *Sociology of Health & Illness* **27**, 649-669.

McCabe MP & Leas L (2008): A qualitative study of primary health care access, barriers and satisfaction among people with mental illness. *Psychology, Health and Medicine* **13**, 303-312.

McCloughen A, Foster K, Kerley D, Delgado C & Turnell A (2016): Physical health and well-being: Experiences and perspectives of young adult mental health consumers. *Int J Ment Health Nurs*.

McDonald DD, Frakes M, Apostolidis B, Armstrong B, Goldblatt S & Bernardo D (2003): Effect of a psychiatric diagnosis on nursing care for nonpsychiatric problems. *Research in nursing & health* **26**, 225-232.

Mental Health Council of Australia (2005) Not for service: experiences of injustice and despair in the mental health care in Australia. Mental Health Council of Australia, Canberra.

Mestdagh A & Hansen B (2014): Stigma in patients with schizophrenia receiving community mental health care: a review of qualitative studies. *Social Psychiatry Psychiatric Epidemiology* **49**, 79-87.

Moore S, Shiers D, Daly B, Mitchell AJ & Gaughran F (2015): Promoting physical health for people with schizophrenia by reducing disparities in medical and dental care. *Acta Psychiatrica Scandinavica (in press)* **132**, 109-121.

Morgan VA, McGrath JJ, Jablensky A, Badcock JC, Waterreus A, Bush R, Carr V, Castle D, Cohen M, Galletly C, Harvey C, Hocking B, McGorry P, Neil AL, Saw S, Shah S, Stain HJ & Mackinnon A (2013): Psychosis prevalence and physical, metabolic and cognitive co-morbidity: data from the second Australian national survey of psychosis. *Psychological Medicine*, 1-14.

Nash M (2013): Diagnostic overshadowing: a potential barrier to physical health care for mental health service users: Michael Nash outlines how physical symptom reports among people with mental health problems are often attributed to mental illness, leading to delayed diagnosis and treatment. *Mental Health Practice* **17**, 22-26.

National Alliance on Mental Illness (NAMI) (2008) Schizophrenia: Public Attitudes, Personal Needs: Views From People Living With

Schizophrenia, Caregivers, and the General Public. . National Alliance on Mental Illness, Arlington, VA.

Noblett JE, Lawrence R & Smith JG (2015): The attitudes of general hospital doctors toward patients with comorbid mental illness. *The International Journal of Psychiatry in Medicine*, 0091217415612721.

O'Donoghue B, Schäfer MR, Becker J, Papageorgiou K & Amminger GP (2014): Metabolic changes in first-episode early-onset schizophrenia with second-generation antipsychotics. *Early Intervention in Psychiatry* **8**, 276-280.

Pirraglia PA, Rowland E, Wu WC, Friedmann PD, O'Toole TP, Cohen LB & Taveira TH (2012): Benefits of a primary care clinic co-located and integrated in a mental health setting for veterans with serious mental illness. *Prevention of Chronic Disease* **9**, E51.

Procter N, Backhouse J, Cother I, Ferguson M, Fielder A, Jackson A, Murison J & Reilly JA (2015a): Engaging consumers in the Australian emergency mental health context: a qualitative perspective from clinicians working in the community. *Health & social care in the community* **23**, 428-436.

Procter N, Ferguson M, Backhouse J, Cother I, Jackson A, Murison J & Reilly JA (2015b): Face to face, person to person: Skills and attributes deployed by rural mental health clinicians when engaging with consumers. *Australian Journal of Rural Health* **23**, 352-358.

Rice P & Ezzy D (2005) *Qualitative Research Methods*. Oxford University Press., Oxford.

- Robson D & Gray R (2007): Serious mental illness and physical health problems: a discussion paper. *International Journal of Nursing Studies* **44**, 457-466.
- Scott D & Happell B (2011): The high prevalence of poor physical health and unhealthy lifestyle behaviours in individuals with severe mental illness. *Issues in Mental Health Nursing* **32**, 589-597.
- Scott D & Happell B (2012): Utilization and Perceptions of Primary Health Care Services in Australian Adults with Mental Illness. *Population Health Management* **16**, 208-213.
- Shefer G, Cross S, Howard LM, Murray J, Thornicroft G & Henderson C (2015): Improving the diagnosis of physical illness in patients with mental illness who present in emergency departments: consensus study. *J Psychosom Res* **78**, 346-351.
- Shefer G, Henderson C, Howard LM, Murray J & Thornicroft G (2014): Diagnostic overshadowing and other challenges involved in the diagnostic process of patients with mental illness who present in emergency departments with physical symptoms--a qualitative study. *PLoS One* **9**, e111682.
- Shippee ND, Domecq Garces JP, Prutsky Lopez GJ, Wang Z, Elraiyah TA, Nabhan M, Brito JP, Boehmer K, Hasan R & Firwana B (2015): Patient and service user engagement in research: a systematic review and synthesized framework. *Health Expectations* **18**, 1151-1166.
- Stebbens R (2001) *Exploratory research in the social sciences: Qualitative research methods: Volume 48*. Sage Publications, London.

Thornicroft G (2011): Physical health disparities and mental illness: the scandal of premature mortality. *The British Journal of Psychiatry* **199**, 441-442.

Thornicroft G, Rose D, Kassam A & Sartorius N (2007): Stigma: ignorance, prejudice or discrimination? *The British Journal of Psychiatry* **190**, 192-193.

Van Nieuwenhuizen A, Henderson C, Kassam A, Graham T, Murray J, Howard L & Thornicroft G (2013): Emergency department staff views and experiences on diagnostic overshadowing related to people with mental illness. *Epidemiology and psychiatric sciences* **22**, 255-262.

Vancampfort D, Knapen J, Probst M, Scheewe T, Remans S & De Hert M (2012): A systematic review of correlates of physical activity in patients with schizophrenia. *Acta Psychiatrica Scandinavica (in press)* **125**, 352-362.

Viron M, Baggett T, Hill M & Freudenreich O (2012): Schizophrenia for primary care providers: how to contribute to the care of a vulnerable patient population. *The American Journal of Medicine* **125**, 223-230.

Wardig RE, Foldemo A, Hultsjo S, Lindstrom T & Bachrach-Lindstrom M (2016): An Intervention with Physical Activity and Lifestyle Counseling Improves Health-Related Quality of Life and Shows Small Improvements in Metabolic Risks in Persons with Psychosis. *Issues in Mental Health Nursing* **37**, 43-52.

Waterreus A, Morgan VA, Castle D, Galletly C, Jablensky A, Di Prinzio P & Shah S (2012): Medication for psychosis--consumption and consequences: the second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry* **46**, 762-773.

Weissman E, Jackson C, Schooler N, Goetz R & Essock S (2012): Monitoring metabolic side effects when initiating treatment with second-generation antipsychotic medication. *Clinical Schizophrenia & Related Psychoses* **5**, 201-207.

White J, Gray RJ, Swift L, Barton GR & Jones M (2011): The serious mental illness health improvement profile HIP : study protocol for a cluster randomised controlled trial. *Trials* **12**.

Wood DS & Tracey TJG (2009): A brief feedback intervention for diagnostic overshadowing. *Training and Education in Professional Psychology* **3**, 218-225.

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