

ETHICS AND MENTAL HEALTH DIAGNOSIS



INTERESTING QUESTIONS REGARDING DIAGNOSIS



Are some individuals more likely to be diagnosed than others?



Does race or ethnicity have an impact on diagnostic judgement?



Does SES influence the likelihood of being diagnosed with an illness?



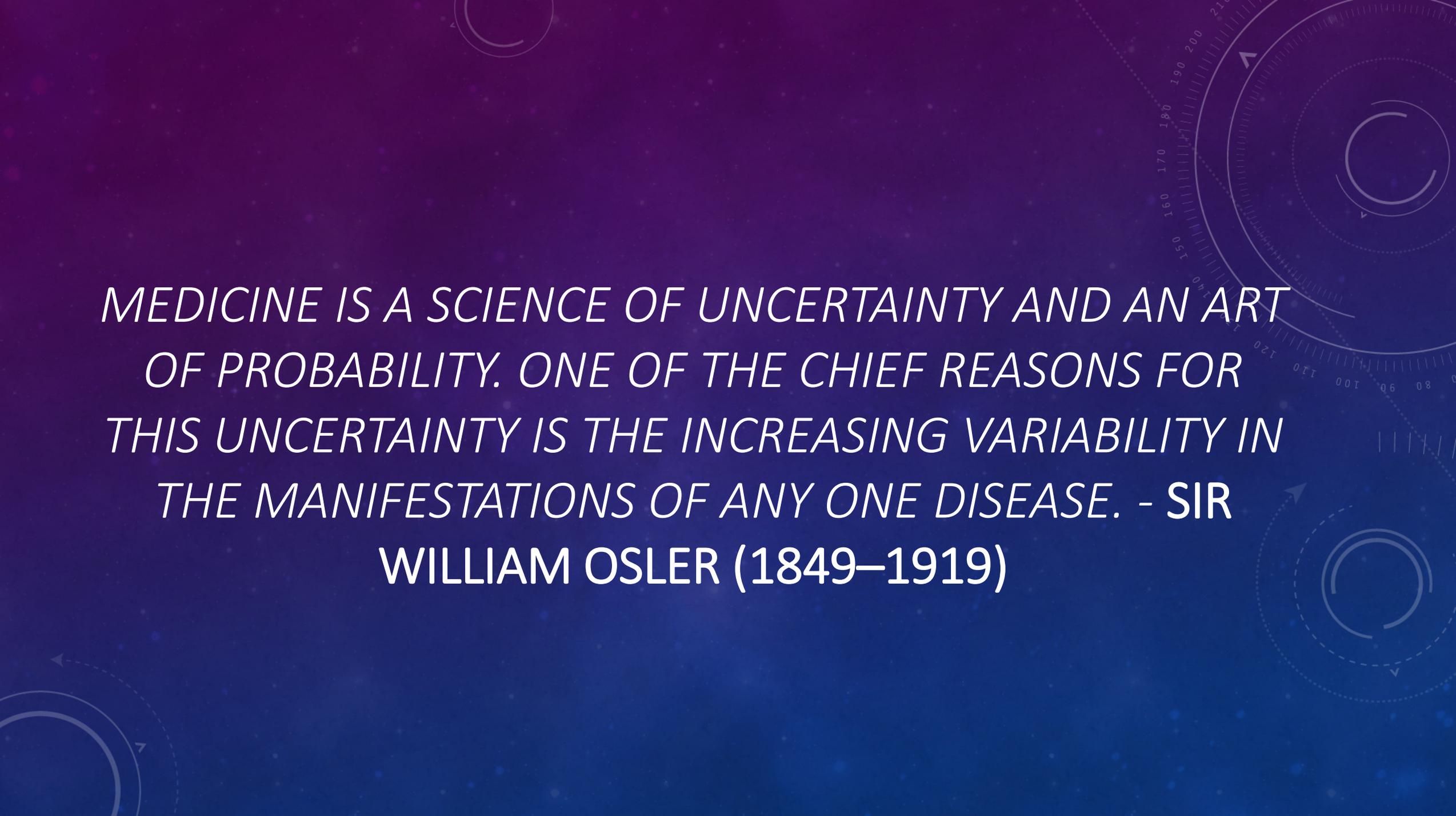
When is diagnosis inappropriate, and how does the clinical weigh the risk?



Are mental health clinicians compelled to diagnose those they examine or treat?

BRIEF HISTORY OF DIAGNOSIS

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MEDICINE IS A SCIENCE OF UNCERTAINTY AND AN ART OF PROBABILITY. ONE OF THE CHIEF REASONS FOR THIS UNCERTAINTY IS THE INCREASING VARIABILITY IN THE MANIFESTATIONS OF ANY ONE DISEASE. - SIR WILLIAM OSLER (1849–1919)

BRIEF HISTORY OF DIAGNOSIS

“Every human act that implies a relation with the external world, presupposes a cognitive distancing of the agent from the area of reality to which act refers” – Pedro Lain-Entralgo, University of Madrid

Diagnosis, takes for granted a sound judgment on the part of the practitioner which is largely influential with two key components:

- The Agents (those having the power to act) and,
- Reality (individual or collective experience)
- Cognitive distancing and what inform the decisions we make?
 - Cognitive infers the mental faculty of knowing, which includes perceiving, recognizing, conceiving, judging, reasoning, and imagining.
- Diagnosis is grounded in interpretive knowledge as opposed to strictly empirical.

HISTORY OF DIAGNOSIS (REIG, 1992)

Cognitive Category	Means of Conceptualization	Basis of Diagnosis	Time Period
Interpretive	(1) Experiential	Diagnosis based exclusively on sensory data and experience	Pre- Hippocratic Origin of humanity to 5 th or 6 th Century B.C.
Interpretive	(2) Magical	Diagnosis based on possession of superhuman potency	
Interpretive	(3) Imaginative	Diagnosis based on creative, non-magical characteristics	
Empirical and Interpretive	(4) Rational	Diagnosis based on experience and reason	Post-Hippocratic 4 th Century B.C. to present (in various forms and capacities)

HISTORY OF DIAGNOSIS

- The word “diagignoskein” emerges within Hippocratic writings designating the meaning of “being ill”
- Experience and reason begins to emerge in interpreting and treating illness
- Now diagnostic error is possible
- Accountability of the physician can be assumed

HISTORY OF DIAGNOSIS

- Emergence of Differential Diagnosis in the Early and Middle Ages (0 to 1000 A.D.)
- Dealing with the “sick” is essential during this time period
- Illness becomes no longer the consequence of moral or religious transgression, yet provides an avenue for finding salvation or “healing” place
- Good medical care was not the same as “treating the ill”

HISTORY OF DIAGNOSIS

- The stratification of society had ethical implications regarding diagnosis
- How might “social prestige” impact diagnosis?
- Physicians consider the preservation of their prestige an ethical duty, to be safeguarded at all costs
- Privileged strata are attended to in justice imposed by nature
- The poor are tended to in charitable ways

HISTORY OF DIAGNOSIS

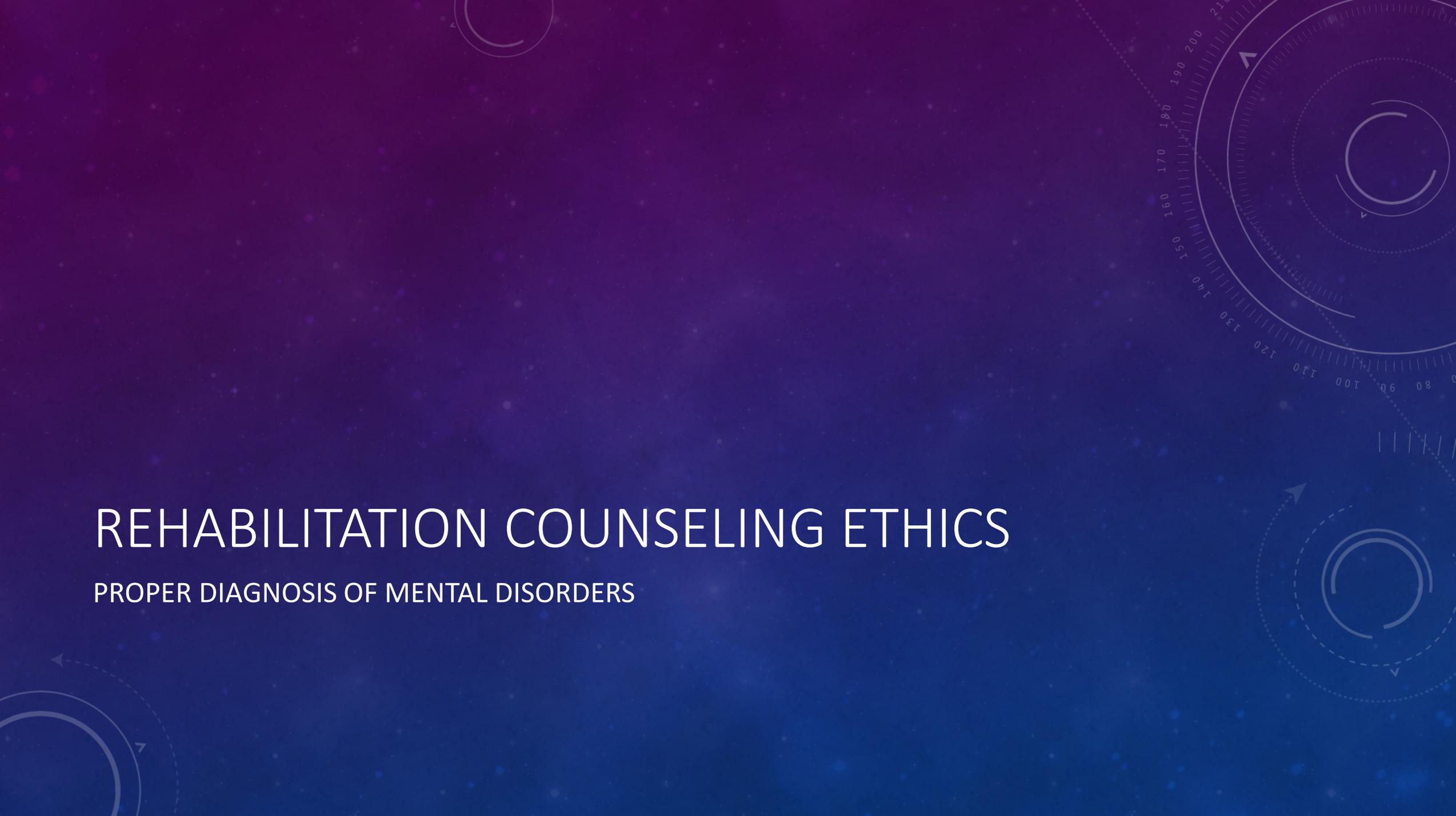
- In more contemporary times, theoretical and practical conflicts began to arise
- Religious ideology in regards to "being ill" and "being cured" begins to give way to rationality and medical knowledge
- Freidrich Hoffmann (1742) published Rule of Prudence still showed a strong association between religion and medical practice, however one of the first to propose that truly knowing the disease (i.e., diagnosing properly) is not only through critical explanation or interpretation of a religious text, but also through direct observation of natural reality

TODAY

- Emphasis on coordination and centralized criteria associated with diagnosis (i.e., DSM V, ICD-10, PIRM, etc.)
- Diagnosis being promoted for providing access to treatment and services, as well as diagnosis needed for allowing access to treatment and services
- Continuing debates on how to improve client safety, reduce stigma, and promote health through diagnosis
- Emergence of algorithms and computer diagnosis

REHABILITATION COUNSELING ETHICS

PROPER DIAGNOSIS OF MENTAL DISORDERS



REHABILITATION COUNSELING SCOPE OF PRACTICE

- Rehabilitation counseling is a systematic process which assists persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process. The counseling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and behavioral interventions. The specific techniques and modalities utilized within this rehabilitation counseling process may include, but are not limited to:
 - assessment and appraisal;
 - **diagnosis and treatment planning;**
 - career (vocational) counseling;
 - individual and group counseling treatment interventions focused on facilitating adjustments to the
 - medical and psychosocial impact of disability;

G.3. PROPER DIAGNOSIS OF MENTAL DISORDERS

- a. **PROPER DIAGNOSIS.** If it is within their professional and individual scope of practice, rehabilitation counselors take special care to provide proper diagnosis of mental disorders using the most current diagnostic criteria. Assessment techniques (including personal interviews) used to determine care of clients (e.g., focus of treatment, types of treatment, or recommended follow-up) are selected carefully and used appropriately.
- b. **CULTURAL SENSITIVITY.** Rehabilitation counselors recognize that culture affects the manner in which a client's symptoms are defined and experienced. A client's socioeconomic and cultural experiences are considered when diagnosing mental disorders.

G.3. PROPER DIAGNOSIS OF MENTAL DISORDERS (CONT.)

- c. HISTORICAL AND SOCIAL PREJUDICES IN THE DIAGNOSIS OF PATHOLOGY. Rehabilitation counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups, and strive to become aware of and address such biases in themselves or others.
- d. REFRAINING FROM DIAGNOSIS. Rehabilitation counselors may refrain from making and/or reporting a diagnosis if they believe that it would cause harm to the client or others. Rehabilitation counselors carefully consider both the positive and negative implications of a diagnosis.

DIAGNOSTIC CONSIDERATIONS
OF MENTAL ILLNESS ACROSS
VARIOUS ETHICAL PRINCIPLES

DIAGNOSTIC CONSIDERATIONS OF MENTAL ILLNESS ACROSS VARIOUS ETHICAL PRINCIPLES

(CORNETT AND HALL, 2008)

Autonomy: To respect the rights of clients to be self-governing within their social and cultural framework.

Example: A number of studies have found that a majority of families request that dementia diagnoses not be disclosed to their loved one due to their fear of the negative psychological impact of the diagnosis (Maguire, 1996; Pucci, Belardinelli, Borsetti, & Giuliani, 2003; Smith & Beattie, 2001) and for fear that their loved one lacks the capacity to make decisions for themselves (Hirschman et al., 2005).

DIAGNOSTIC CONSIDERATIONS OF MENTAL ILLNESS ACROSS VARIOUS ETHICAL PRINCIPLES

(CORNETT AND HALL, 2008)

Beneficence: To do good to others; to promote the well-being of clients.

Example: The patient's awareness of the nature and severity of their cognitive deficits is another issue for consideration ([Whitehouse, Frisoni, & Post, 2004](#)). An individual who possesses good insight and awareness into their deficits is able to verbalize the nature, the severity, and the consequences that their deficits can have on themselves and others. The extent of this awareness has been associated with the patient's psychological response to receiving a dementia diagnosis ([Whitehouse et al., 2004](#)).

Prior to receiving a diagnosis, individuals who are aware of their cognitive deficits may experience feelings of isolation and confusion due to their uncertainty of whether they are developing a cognitive disorder ([Vernooij-Dassen et al., 2005](#)). [Maguire \(1996\)](#) found that the more aware persons are of their deficits, the more at risk they are for experiencing adverse psychological outcomes subsequent receiving a diagnosis of dementia.

The patient in the late mild to moderate stages of Alzheimer's may not have adequate awareness to relate the diagnosis of dementia to their own behavior and will likely not benefit from disclosure.

DIAGNOSTIC CONSIDERATIONS OF MENTAL ILLNESS ACROSS VARIOUS ETHICAL PRINCIPLES

(CORNETT AND HALL, 2008)

Nonmaleficence: To do no harm to others.

Example: There has been a concern that patients receiving a diagnosis may experience psychological harm (Pinner & Bouman, 2003; Pucci et al., 2003; Smith & Beattie, 2001). This harm may occur in the form of depression (Smith & Beattie, 2001; Waite, Bebbington, Skelton-Robinson, & Orrell, 2004) and/or suicidal ideation (Carpenter & Dave, 2004; Jha, Tabet, & Orrell, 2001). Although this concern is widely held, there is no significant evidence that being told a dementia diagnosis causes depression (Jha et al., 2001).

A recent exploratory qualitative study of the emotional impact of disclosure (Amirinzadeh, Byszewski, Molnar, & Eisner, 2007) found a range of responses from active denial, to grief to positive coping in response to a dementia diagnosis. Applying the principle of “do no harm” requires the neuropsychologist to take into consideration the patient's history of depression, available cognitive and social resources and coping skills in the decision to disclose.

DIAGNOSTIC CONSIDERATIONS OF MENTAL ILLNESS ACROSS VARIOUS ETHICAL PRINCIPLES

(CORNETT AND HALL, 2008)

Veracity: To be honest.

Example: Helping the patient and providing the best treatment for the patient requires giving the patient the best information available. In the past, it has been common practice ([Downs, 1999](#), [Tuckett, 2004](#)) for health care professionals to either not tell the patient the truth about their diagnosis, or to use deceit when delivering the diagnosis. The patient may be told that they have “memory problems” or “have trouble remembering” ([Pinner & Bouman, 2003](#)) instead of being told their actual diagnosis of dementia. Even though this has been common practice in medical settings, most patients want their clinician to be truthful with them ([Tuckett, 2004](#), [Jha et al., 2001](#)).

The practice of not being truthful with the patient has significant consequences.

Deceit can greatly compromise the professional relationship ([Marzanski, 2000](#); [Wilkinson & Milne, 2003](#)) and can lead to a breakdown of the patients’ trust. This loss of trust increases the likelihood of the patient having a negative emotional response ([Waite et al., 2004](#)). Deceit can be seen as infringing on the rights of the patient ([Marzanski, 2000](#)) and can impact the patient's relationship with family members as well as health care professionals ([Pinner & Bouman, 2003](#)).

DIAGNOSTIC CONSIDERATIONS OF MENTAL ILLNESS ACROSS VARIOUS ETHICAL PRINCIPLES

Additional Ethical Principles to Consider:

- Fidelity: To be faithful; to keep promises and honor the trust placed in rehabilitation counselors.
- Justice: To be fair in the treatment of all clients; to provide appropriate services to all.

What are some potentially important diagnostic considerations based on these ethical principles that impact well-being?

CHARACTERISTICS OF DIAGNOSTIC CLASSIFICATION AND DIAGNOSIS

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CHARACTERISTICS OF DIAGNOSTIC CLASSIFICATION

(SANDERSON AND ANDREWS, 2002)

- Diagnosis and the classification of mental disorders is built on observation of pathological human behaviors.
- It identifies patterns of signs or symptoms that are stable over time and across different cultural settings, and can be informed by new knowledge of the way the mind and brain work.
- Diagnostic classification is a reflection of:
 - a natural observable phenomena,
 - cultural ways of understanding these, and
 - the social context in which these experiences occur.

CHARACTERISTICS OF DIAGNOSTIC CLASSIFICATION

(SANDERSON AND ANDREWS, 2002)

- Diagnostic classification is characterized by our understanding of:
 - genetics,
 - physiology,
 - individual development,
 - behavioral patterns,
 - interpersonal relations,
 - Family structures,
 - social changes, and
 - cultural factors

This all makes the task of creating a classification of mental disorders challenging

WHAT IS DIAGNOSIS?

As a Process →

- Analyzing of the cause or nature of a condition, situation, or problem (merriam-webster.com)
- Examining the nature and circumstances of a diseased condition and the decision reached from such an examination (dictionary.com)
- Determining the nature and cause of a disease or injury through evaluation of patient history, examination, and review of laboratory data (American Heritage Medical Dictionary)

WHAT IS DIAGNOSIS?

As a Label →

- The art of naming a disease or condition (Mosby's Medical Dictionary)
- A statement or conclusion from such an analysis or the decision reached by diagnosis(merriam-webster.com)

Common terms associated with diagnosis: conclusion, decision, deliverance, determination, judgment (or judgement), opinion, resolution, verdict

DIAGNOSIS INFORMED BY SOCIAL EXPECTATIONS

- Diagnosis supported by clinical and laboratory findings that have been made due to social expectations (examples):
 - Home Function – What level of function and characteristics expected given a particular sex or age?
 - Human Form and Action – What freedom of pain should characterize the human experience?
 - Life Expectancy - What age is expected to be associated with end of life?



TYPES OF DIAGNOSIS

1. Clinical diagnosis: diagnosis based on signs, symptoms, and laboratory findings during life.
2. Differential diagnosis: the determination of which one of several diseases may be producing the symptoms.
3. Medical diagnosis: diagnosis based on information from sources such as findings from a physical examination, interview with the patient or family or both, medical history of the patient and family, and clinical findings as reported by laboratory tests and radiologic studies.
4. Physical diagnosis: diagnosis based on information obtained by inspection, palpation, percussion, and auscultation.
5. Diagnosis-Related Groups (DRG): a system of classification or grouping of patients according to medical diagnosis for purposes of paying hospitalization costs.

NUMBER OF DIAGNOSES

- Diagnostic Statistical Manual (DSM) has approximately 157 diagnosable disorders or illnesses, and nearly 600 discrete disorders when accounting for scaling. Therefore, arguably thousands of classifications when adding specifiers.
- The **International Classification of Diseases (ICD)** is the international "standard diagnostic tool for epidemiology, health management and clinical purposes. The ICD is originally designed as a health care classification system, providing a system of diagnostic codes for classifying diseases, including nuanced classifications of a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease.
- Between 600 and 700 Mental Health Billable Diagnosis Codes in the ICD-10

WHY DIAGNOSIS? WHY THE LABELS?

Diagnosis allow for classifying individuals for both treatment and research purposes.

Diagnostic labels serve three main goals:

1. They provide an efficient way for clinicians and researchers to understand a large amount of information ([Frances, First, Pincus, Widiger, & Davis, 1990](#))
2. They also provide a convenient means for describing patients that includes the presentation of symptoms and may imply the expected course and prognosis.
3. Lastly, diagnostic labels may suggest etiology as well as point the way toward specific interventions that may prevent or ameliorate the consequences of the condition ([Corrigan, 2007](#)).

INFLUENCING CHARACTERISTICS: COST, TIME, & ERRORS

- Macro and Micro Perspective (as it relates to diagnosis):
 - Macro – Impact of cost and benefits on society
 - Availability and adequacy health care, community and social support systems
 - Generally the longer it takes to (accurately) diagnose the patient or client, the higher the cost related to treatment
 - Micro – Impact of cost and benefit on the individual
 - Access to health care, benefits, and social support
 - Generally, the longer it takes to have an accurate diagnosis, the higher the cost to the individual and society

INFLUENCING CHARACTERISTICS: COGNITIVE HEURISTICS AND BIASES

Common Heuristics:

- 1) The representative heuristic leads clinicians to judge the probability of a disease by how closely a patient presentation matches a prototypical case without considering the prevalence of a disease
- 2) The availability heuristic leads the clinician to judge the probability of a disease on the basis of how easily that disease is recalled, which is often skewed by recent and memorable cases.
- 3) The anchoring heuristic leads clinicians to cling to their initial diagnostic hypotheses even as contradictory evidence accumulates

INFLUENCING CHARACTERISTICS: COGNITIVE HEURISTICS, BIASES AND ACTIONS

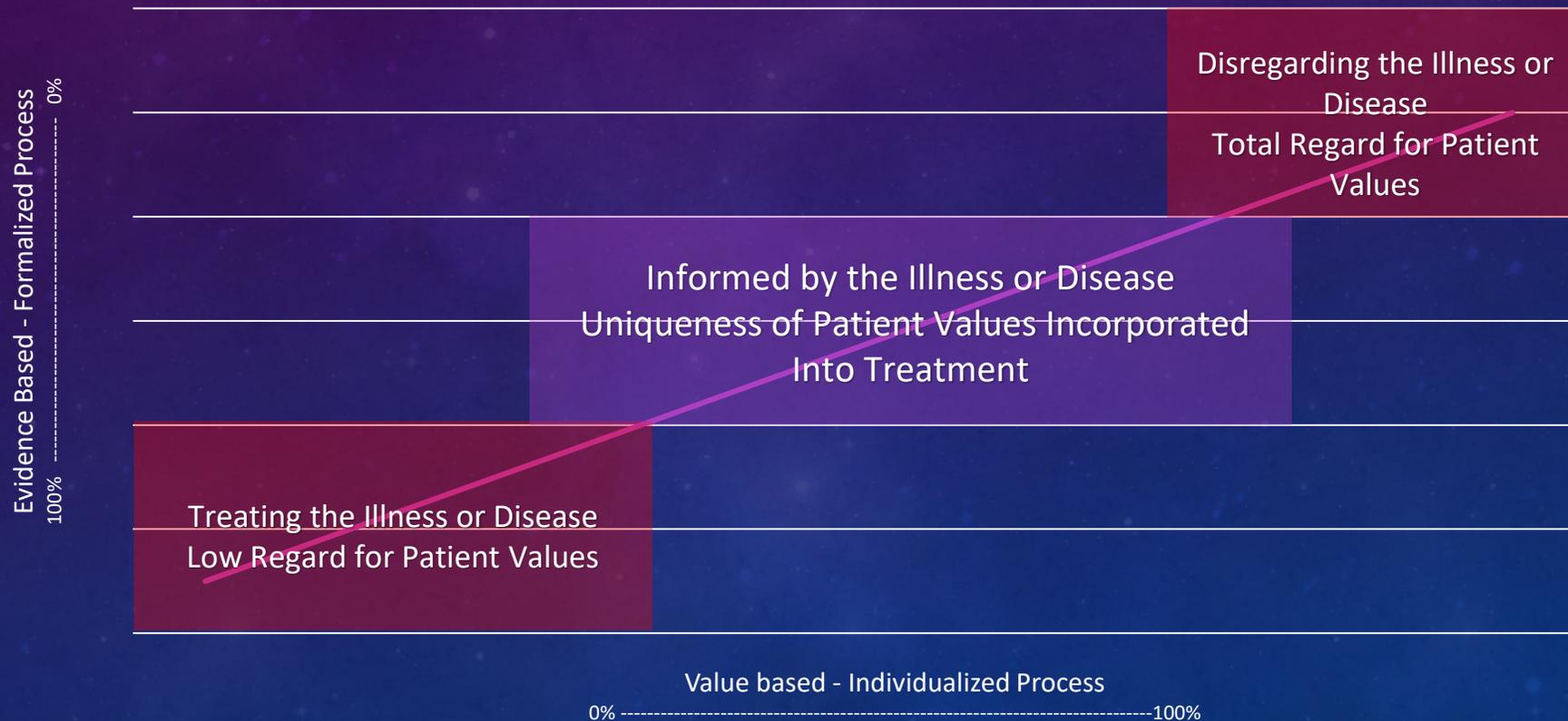
Most Common Biases or Actions:

- 1) *Premature closure* describes settling on a diagnosis without sufficient evidence or without seeking or carefully considering contradictory information.
- 2) *Confirmation bias*, is the tendency to look for evidence to support a working hypothesis, ignore contradictory evidence, and misinterpret ambiguous evidence.

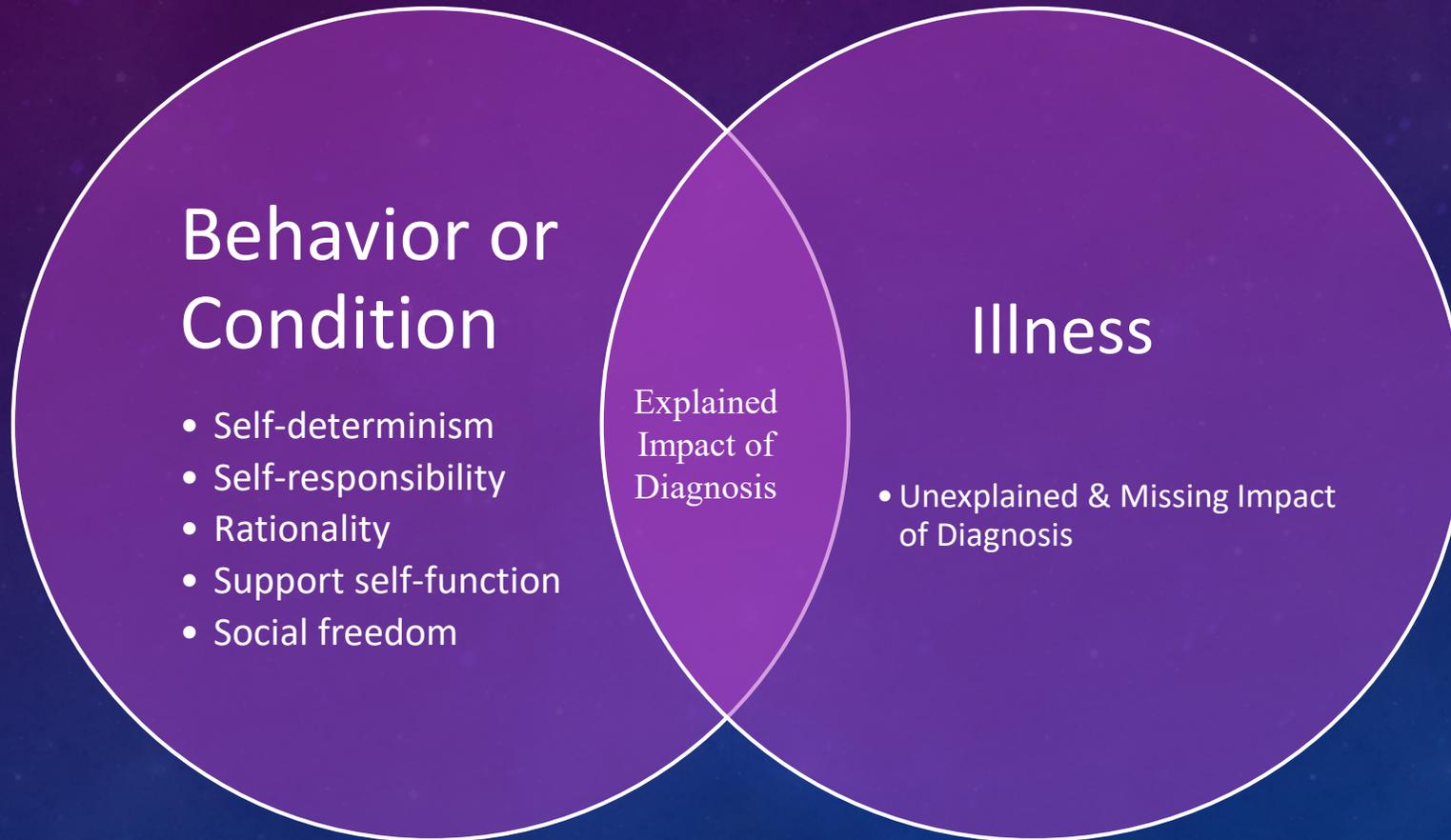
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TWO IMPORTANT VIEWS ON THE IMPACT OF DIAGNOSIS

STANDARDIZED V. NON-STANDARDIZED DIAGNOSIS AND TREATMENT CONTINUUM (HELMCHEN AND SARTORIOUS, 2010).



HOW BROAD OR NARROW THE DIAGNOSIS?

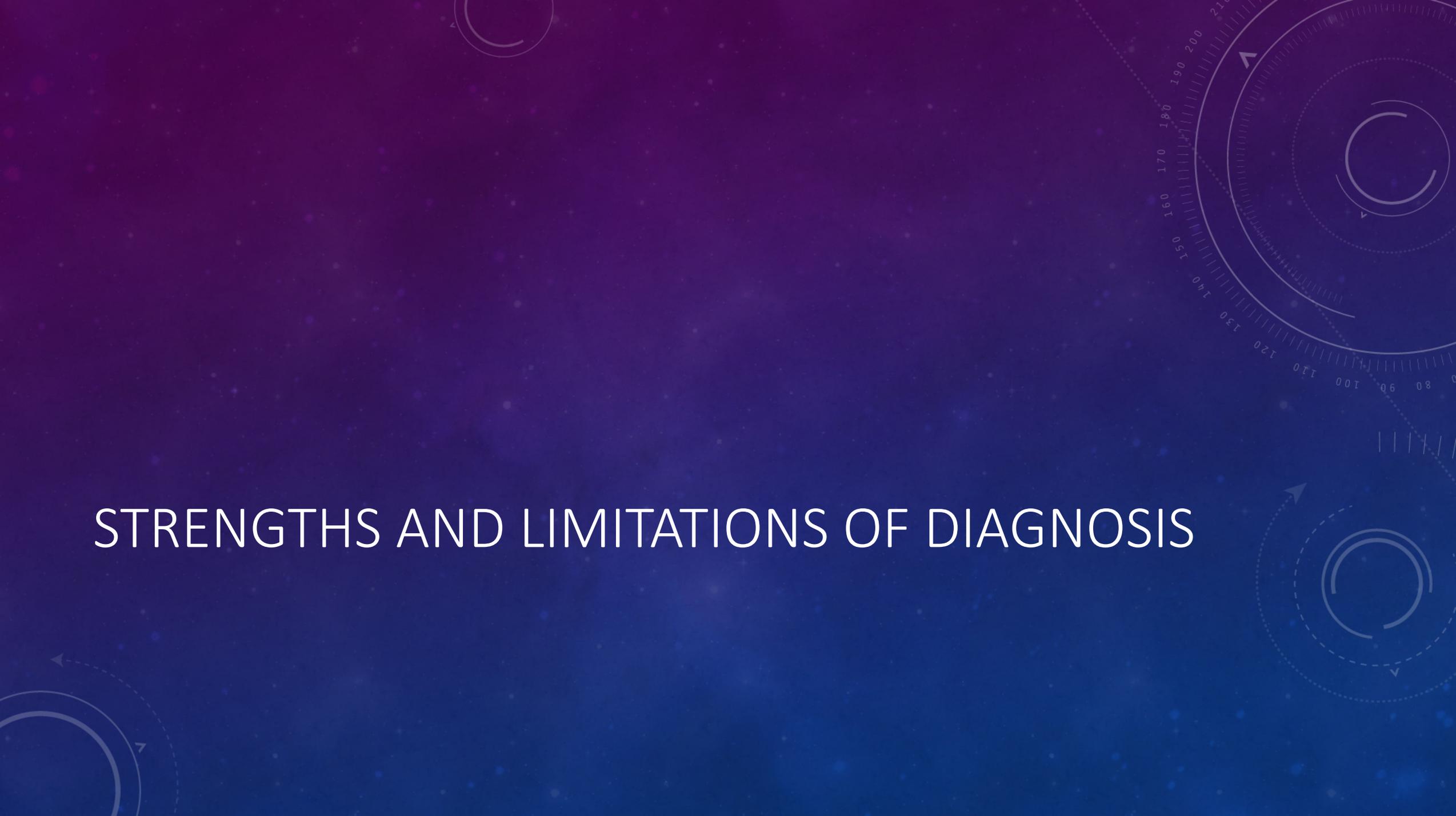


(Finzen, 2000)

IMPACT OF DIAGNOSIS

- According to [Goffman \(1963\)](#), assigning meaning to a diagnostic label entails the recognition that the person with the label differs in some way from the general public.
- In the [Lingler et al. \(2006\)](#) study, the meaning participants assigned to their diagnoses varied widely depending on their expectations related to normal aging, personal experience with dementia, and concurrent health problems.
 - For example, an individual who viewed memory loss as an expected part of the aging process was relatively unaffected by the MCI label, stating, “It's just a matter of putting a name on the condition I was aware of” ([Lingler et al., 2006](#), p. 796). By contrast, those who viewed MCI as a definite precursor to Alzheimer's disease voiced significant distress.
- Therefore, theoretically, as public awareness increases regarding the organic etiology of behavioral or cognitive impairment—or if public knowledge increases regarding the benefits of treatment for such related conditions—we might expect that stigma associated with these conditions would be lessened.

STRENGTHS AND LIMITATIONS OF DIAGNOSIS

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STRENGTHS AND LIMITATIONS

- Important Questions:
 - Is it possible to medicalize diagnosis?
 - Is there a need to resist the “treatment imperative”.
 - Can suffering have meaning? What is “normal aging”

Many elderly patients resist taking medicine regardless of the level of suffering, or the potential benefit of taking medication.

Medical ethicists have voiced that the inappropriate medicalization of suffering that otherwise have meaning for elderly persons should be resisted (Lidz and Parker, 2003).

STRENGTHS AND LIMITATIONS

Task Chart and Relative Diagnosis

How might any diagnosis be influenced by age?

Age Category	Age	Event	Diagnosis
Pre-adolescent	3-9	Recent loss of a loved one impacts client's emotional stability, sleep pattern is disrupted, and has feelings of isolation and sadness. Condition interferes with social and occupational functioning	?
Adolescent	10-12		
Teenager	13-17		
Young Adult	18-24		vs
Adult	25-44		
Older Adult	45-65		
Advanced Adult	66-75		
Elderly Adult	76-99		?

STRENGTHS AND LIMITATIONS

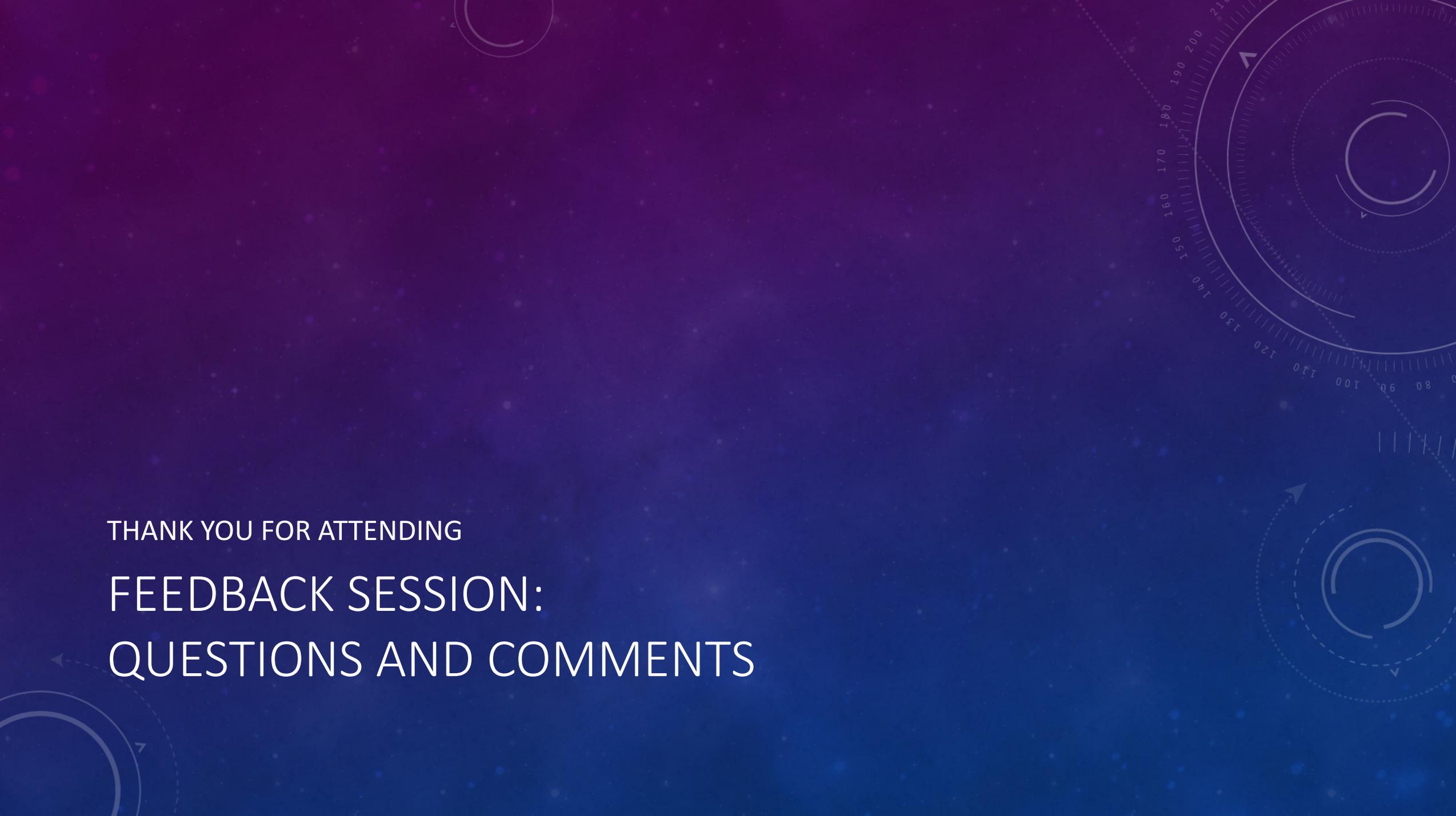
- Access to proper treatment and care for a disease and illness
- Helps clinicians communicate with each other by identifying patterns linked to disability, interventions and outcomes.
- Cost savings associated with diagnosis and treatment
 - For example: For community-dwelling AD patients, two major costs are incurred: the patient's direct medical costs and the indirect cost of caregivers' lost productivity (*Small GW, McDonnell DD, Brooks RL et al., 2003*)
- Diagnosis can result in inclusion rather than exclusion.

STRENGTHS AND **LIMITATIONS**

- Diagnoses can be based on non-scientific explanations
- Many diagnoses are classified or confirmed based on ill-defined or subjective terms (i.e., normal, severe, significant, etc.).
- Clinical diagnosis relies upon the veracity of the client or patient.
- Diagnosis can restrict personal liberty.
- Diagnosis can be stigmatizing.
- Diagnosis can be influenced by confirmation bias.
- Diagnostic labels can serve as cues that activate stigma and stereotypes.
- Diagnosis can take away feelings of responsibility for behavior and for efforts to overcome.

IMPLICATIONS FOR PRACTICE

- Partnering with patients in the diagnostic process and adopting a reflective mode of practice in which learning from feedback is the norm
- Seek out feedback with other clinicians, experts, and patients.
- Approach diagnosis as a team process, leveraging the strengths of other team members – encouraging the principle treater to seek help or confirmation
- Seek out research and other safety professionals to develop resources to help institutions and clinicians operationally define and identify diagnostic errors
- Recognize the “umbrella effect” implied by terminology presently used or implicitly associated with diagnosis
- Become aware of cognitive errors in order to develop *cognitive forcing strategies* that help to subvert errors in real time

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THANK YOU FOR ATTENDING
FEEDBACK SESSION:
QUESTIONS AND COMMENTS

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