Piecing Together an Accurate Diagnosis

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Audience Input:

Why is having an accurate diagnosis important?

How do we get an accurate diagnosis?
Todays Objectives

- Participants will learn how to collect appropriate information for accurate diagnosing.
- Participants will learn how to look at symptoms as a whole to make an accurate and precise diagnosis.
- Participants will learn how to continuously assess to ensure timely updates and accurate diagnosing over time.
Definition of a Mental Disorder:

- Audience Ideas?

- “A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processed underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above”. (DSM-5, page 20)

- “The diagnosis of a mental disorder should have clinical utility: it should help clinicians to determine prognosis, treatment plans, and potential treatment outcomes for the patients. However, the diagnosis of a mental disorder is not equivalent to a need for treatment.” (DSM-5, page 20)

- “It is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis....It requires clinical training to recognize when the combination of predisposing, precipitating, perpetuating, and protective factors has resulted in a psychopathological condition in which physical signs and symptoms exceed normal ranges.” (DSM-5, page 19)
Facts from National Alliance on Mental Illness (NAMI):

- 43.8 million Adults experience mental illness in a given year (1 in 5 adults)
- 13-18% of youth aged 13-18 and approximately 13% of youth aged 8-15 will experience serious mental illness during their life time.
- 60% of adults and 50% of those under 18 didn’t receive mental health services when they needed it in the last year.
- African Americans and Hispanic Americans use mental health services at about ½ the rate of Caucasian Americans, and Asian Americans at about 1/3 the rate.
- Adults living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions.
- Half of chronic mental illness begins by age 14!!
Why does misdiagnosis, under-diagnosis, and over-diagnosis happen?

- We don’t collect the right information
  - Did we ask the right questions?
  - Did we ask too many/ not enough questions?
  - Did we move too fast?
  - Intentionally given inaccurate or misleading information.
  - Did we make assumptions, misinterpret, not consider all facts?
  - Did we consider cultural differences, gender differences, age differences, economic status differences, sexual identity differences, etc in symptom presentation?

- Heuristics- strategies that provide shortcuts to quick decisions
- Unfamiliar with full diagnostic criteria
- Complex and/or Co-occurring Issues
- Intentional due to health policy constraints
Common Misdiagnoses

- **Bi-Polar Disorder**
  - Misdiagnosed as:
    - ADHD
    - Depression
  - 69% initially misdiagnosed

- **Borderline Personality Disorder**
  - Misdiagnosed as:
    - Bi-Polar
    - PTSD
    - Depression
    - ADHD

- **ADHD**
  - Misdiagnosed as:
    - Depression
    - Anxiety
    - OCD
    - Bi-Polar Disorder

- **PTSD**
  - Misdiagnosed as:
    - Mood Disorders
    - Anxiety
    - Behavioral Disorders
    - ADHD
    - Schizophrenia
    - Borderline Personality Disorder
  - Army dismissed over 1000 people between 2005-2007 for a Personality Disorder. In 2008 a new requirement put in place to rule out PTSD resulted in a significant drop of dismissals (around 75%)

- **Anxiety**
  - Misdiagnosed as:
    - ADHD
    - Depression
    - Nothing
“The fool doth think he is wise, but the wise man doth know he is a fool”

- Shakespeare
True or False:
Diagnostic screeners and tools provide clear diagnostic clarification for assigning a diagnosis.
Diagnostic screeners and tools can provide assistance in identifying symptoms and guidance for further assessment and questioning.
Some Tools for your Toolkit!

- **DSM-5 Level 1 and Level 2 Screeners**
  - [https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures](https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures)
  - Adult and Child (7-17) Self Rating Scales and Guardian for under 18 as well

- **Columbia Suicide Severity Rating Scale**
  - [http://cssrs.columbia.edu/](http://cssrs.columbia.edu/)
  - Screener, Clinical Version, Pediatric Version

- **PROMIS® (Patient-Reported Outcomes Measurement Information System)**
  - [http://www.healthmeasures.net/explore-measurement-systems/promis](http://www.healthmeasures.net/explore-measurement-systems/promis)
  - Adult and Child, wide range of available free screeners

- **CRAFFT**
  - Brief screening tool for adolescent substance use

- **SAMHSA**

- Too numerous to list.. BDI, DAPPER-3, SUDDS-5, STABLE Resource Tool Kit, TSC (Trauma Symptom Checklist), GAD-7, PHQ-9...

- Other suggestions to share??

- Bottom Line- Make sure tools are EVIDENCED BASED and you have completed necessary training to administer them!!!
Scenario 1: Collecting Appropriate Info

Carly, a 7 year old African American female presents for an initial assessment. She is with her Caucasian foster parents, whom she has lived with for 9 months. The girl still has bi-weekly visits with her biological parents and has had 2 previous placements in foster care with different families. She is coming to the assessment due to reports of not playing well with others at school, struggling to stay on task at home and school, struggles with school work but will not ask for help and walks away without finishing her work, is withdrawn or becomes aggressive when foster mother tries to comfort her, has poor eye contact and hygiene, is hyperactive and/or fidgety at school, and has frequent wetting and soiling incidents.

What are your first thoughts?
NO!! Don’t make assumptions!!!
Who would you talk to for more information?
What questions would you ask?
What tools would you use?
What characteristics of the client are important in your approach?
Any other considerations?
How to collect information for appropriate diagnosing:

- Collect the “right” information but... what is the “right” information?
  - What does your accrediting body say? CARF, COA, CACREP?

- Get information on the development and history of all reported symptoms, issues, and behaviors.

- Talk to anyone who may offer pertinent information that can assist with identification of symptoms and behaviors. Information across settings is always useful.

- Screenings and Tools that are evidenced based, valid, and reliable. Make sure they are in your scope of practice to administer.

- MAKE SURE YOU HAVE A RELEASE TO TALK TO ANYONE OUTSIDE OF THE CASE
How to collect information for appropriate diagnosing:

- Are we asking the right questions?
  - What role does home environment play?
  - What is the opposite of how they are feeling now and have they felt differently recently?
  - Did we dig into what the symptoms or behaviors look like? Our clients come with their own biases and preconceived notions too. There can also be ambiguity in what is reported so we need to clarify.
  - Any somatic symptoms? Headaches, nausea, aches, pains, etc..
  - Are we getting a clear developmental and medical history?
  - Do we know current medications and a history of medication? We can learn a lot from what has worked and what hasn’t... (stay in your scope)
  - How does culture and religion affect how they are reporting symptoms?
- Are we offering an environment where the client feels safe to give us the needed information?
Let’s practice collecting information for appropriate diagnosing:

- Bob, a 32 year old Caucasian male, comes to an assessment. He has never been in treatment before. Bob initially reports trouble sleeping, trouble concentrating, increased heart rate at times, and feeling intense panic for no reason. He briefly mentions spending too much money on “partying”.

- What now?

- Jose, a 14 year old Hispanic male, comes to an assessment. He is experiencing trouble concentrating, reports he is at times hopeless and has suicidal ideations, has trouble sleeping, and that he has disconnected from friends and sports. Jose also reports that his dad would often hit him because he “moved around a lot” and beat up his mom but that he has been incarcerated for over a year. Mom reports that Jose is defiant at home and his teachers report to her that he won’t complete his work and is a disturbance to class. He has been in two fights in the last few months.

- What now?
Now that we have all of the information, what do we do with it??

Now What???
Current Issues with Diagnosing:

- Clinicians are inclined to diagnose disorders they are more familiar with and feel more comfortable treating.

- Evidence shows that when there is a question in diagnosing, clinicians err on the side of:
  - The disorder that is medication responsive
  - The disorder is within the scope of their own treatment or that of their agency

- We don’t take into consideration ALL of the factors.
  - Cultural
  - Medical
  - Medication
  - Substance Abuse
  - Previous Treatment
  - Genetics
  - What else?
Current Issues with Diagnosing:

- Five Pitfalls in Decisions About Diagnosing and Prescribing
  - Jill Klein, 2005, The BMJ
  1) Insensitivity to Known Possibilities- giving too much weight to one piece of information
  2) Overconfidence- be aware of limits
  3) Failure to Consider Other Options- making quick assumptions, stop asking questions when the info meets your assumption
  4) Illusory Correlation- seeing what we want to see
  5) Availability/Familiarity- going with what we know

- Cognitive biases lead to poor decision making

- Can be overcome by 1) Continuous Training, 2) Be Aware of Base Rates, 3) Challenge Your Own Decision- ask questions to disprove, 4) and Consider all relevant data
What tools do you use to diagnose?

- **DSM-5**
  - ALL criteria must be met to give the diagnosis
  - Pay attention to the additional information and guidance listed after the criteria:
    - Features and Associated Features
    - Comorbidity
    - Development and Course
    - Prevalence
    - Culture and Gender Related Diagnostic Issues
    - Differential Diagnosis
    - Diagnostic Markers

- **ICD-10**
  - Must be used for billing
  - Blue Book
  - Gives us the ability to report the old Axis 4 information
# Differences between ICD-10 and DSM-5

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<th><strong>ICD-10</strong></th>
<th><strong>DSM-5</strong></th>
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<tr>
<td>Effective October 1, 2015</td>
<td>Effective January 1, 2014</td>
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<td><a href="http://icd10data.com">http://icd10data.com</a></td>
<td>Decision Making Trees</td>
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<td>Have to use this for billing purposes</td>
<td>Provides broader diagnostic criteria that allows medical necessity and access to treatment for “mild” cases that may not meet criteria per the ICD-10</td>
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<td>Provides very specific diagnosis, up to 7 characters</td>
<td>Has traditionally been seen as the “Diagnostic Bible” for clinicians</td>
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<td>Allows for codes that cover old Axis 4 information</td>
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Differences between ICD-10 and DSM-5

- There are 3x as many codes for Substance Use Disorders in the IDC-10 as in DSM-5

- Symptoms and Diagnostic Criteria
  - ADHD (DSM-5) vs Hyperkinetic Disorder (ICD-10)
    - Same numbers
    - ICD-10 Blue Book criteria never mentions “impulsivity” nor has a time frame for symptomology

- Presence of Disorders in one manual and not in the other
  - Asperger's

- Clinical Presentations and Conditions
  - Abuse vs Dependence vs Substance Use Disorder

- Categories and Disorders
  - ICD-10 has a whole “mania” category
Bob, a 32 year old Caucasian male, comes to an assessment. He has never been in treatment before. Bob initially reports trouble sleeping, trouble concentrating, increased heart rate at times, and feeling intense panic for no reason. He briefly mentions spending too much money on “partying”.

More information gathering revealed “partying” meant taking un-prescribed Adderall 5-6 days a week for about 15 months and drinking alcohol with the Adderall on the weekends. The dosage has slowly increased as he has become tolerant. Bob reported that he craves the feeling and uses a lot of his time to find enough Adderall, including missing quite a few days of work, to the point he may lose his job. He indicates that his feelings of panic and increased heart rate typically happen a couple of hours after taking the Adderall.

What is his Diagnosis/es?
Jose, a 14 year old Hispanic male, comes to an assessment. He is experiencing trouble concentrating, reports he is at times hopeless and has suicidal ideations, has trouble sleeping, and that he has disconnected from friends and sports. Jose also reports that his dad would often hit him because he “moved around a lot” and beat up his mom but that he has been incarcerated for over a year. Mom reports that Jose is defiant at home and his teachers report to her that he won’t complete his work and is a disturbance to class. He has been in two fights in the last few months.

Further questioning and screening found that Jose has nightmares that keep him from sleeping through the night 3-4 nights a week. Jose reports a lack of trust in others, especially his mom, and that he can’t remember the last time he was “happy”. He states, “people just set me off easy and I have to get them before they get me”. Jose has refused to go see his father in prison. Teachers indicate that Jose’s grades had gotten better when he was little and was prescribed Ritalin but that they have dropped slowly over the last couple of years and his behaviors have become more defiant and aggressive. They suggest increasing his medication.

What is his diagnosis/es?
Narrowing it down...or not....

- **Discussion:**
  - Do we give every diagnosis someone meets criteria on OR do we give a diagnosis that encompasses the entire picture?

- **Comorbidity**
  - Comorbid diagnoses cannot cause one another
  - Independent, multiple diagnoses

- **Differential Diagnoses**
  - Make a list of all possible diagnoses
  - Objective Findings vs Subjective Judgments
  - What is the “best” explanation of all that is happening
  - Question and Challenge your final diagnosis

- **Questions to ask ourselves (Morrison, 2007):**
  - Are all symptoms covered by the principal diagnosis?
  - What will be the benefits of the additional diagnosis?
  - Do the additional symptoms meet full criteria for the additional disorder?
  - “When symptoms cannot be adequately explained by a single disorder, consider multiple diagnoses” (p. 61).

- Always consider the possibility that there is no diagnosis. Z03.89
- What if you still aren’t sure but there is something there... Z71.9
- Did we consider the “blanket” diagnoses? PTSD, RAD, Personality Disorders
Now that we have a diagnosis, what do we do with it??

“Clinicians err and patients change—two reasons why we must always keep alert to the need for rethinking diagnosis” (Morrison, 2007)
Ongoing Assessment is crucial!!

- Following diagnosis, most clients will begin treatment. It is crucial for the clinician to continue to assess, observe, and gather information.
- Research shows only 80% of initial diagnoses are correct and thorough.
- Reasons for Ongoing Assessment:
  - Updating diagnosis
    - To most specific degree
    - New information obtained or observed
  - Substance Use Disorders
  - Adjustment Disorders
  - Lack of Progress - have we missed something?
  - To Show Progress and/or Continued Needs
  - Other?
Ongoing Assessment

Discussion:
- How do you/your agency do ongoing assessments?
- What tools do you use?

Challenges and Cautions
- Don’t make changes quickly unless warranted. If you see something new or different, you can assess, make referrals, document observations, consult with a supervisor or colleague and then make an informed change if needed. However, sometimes a quick move is necessary for safety and well-being of the client.
- Assess the possible benefits and consequences of a change of diagnosis.
- Be open with your client(s) about your thoughts and gather their input.
- False Positives- diagnoses that turn out to be inaccurate
  - Can lead to stigma
  - May be overlooking a more accurate diagnosis that would lead to the right treatment
  - Happens most when we rely solely on checking off criteria as opposed to understanding context
- False Negatives- when a diagnosis should have been made but wasn’t
  - Clients do not receive the treatment they need
Take-Away Information

- Information Gathering:
  - Get as much and as thorough information as you can
  - Ask questions about origin and development of issues and symptoms
  - Always take culture and beliefs into consideration

- Diagnosing:
  - Look at the whole picture without assumptions
  - Challenge Yourself
  - Participate in Ongoing Training and Consultation

- Ongoing assessment:
  - Crucial for quality care
  - Let’s you and the client know if treatment is working
Questions? Concerns? Thoughts?
References:


