Why you should read this article:
- To understand the link between severe mental illness and suboptimal physical health
- To enhance your knowledge of the complex and multifaceted causes of diagnostic overshadowing
- To contribute towards revalidation as part of your 35 hours of CPD (UK readers)
- To contribute towards your professional development and local registration renewal requirements (non-UK readers)

Preventing diagnostic overshadowing to improve the physical health of people with severe mental illness

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Abstract
People with severe mental illness (SMI) often have suboptimal physical health and associated outcomes. An important issue for mental health nurses to be aware of is diagnostic overshadowing, which occurs when healthcare professionals misattribute a person's physical health symptoms to their existing mental illness. This misattribution increases the likelihood of delays in treatment, potentially giving rise to complications that further negatively influence health outcomes. While the causes of diagnostic overshadowing are complex and multifaceted, mental health nurses need to ensure that their practice is not a contributing factor, which requires ongoing self-reflection on their knowledge, skills and attitudes. This article defines diagnostic overshadowing, proposes potential explanations for why it may occur and offers practical strategies to prevent it. Raising awareness of diagnostic overshadowing could help to improve physical health outcomes for people with SMI.

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Keywords
comorbidity, decision making, discrimination, diversity, mental health, nursing care, patient experience, patients, professional, professional issues, stigma

Aims and intended learning outcomes
The aim of this article is to enhance mental health nurses' awareness of diagnostic overshadowing in relation to the physical health of people with severe mental illness (SMI), so that they can recognise and prevent its occurrence. After reading this article and completing the time out activities you should be able to:
» Explain why people with SMI experience worse physical health outcomes compared with the general population.
» Define diagnostic overshadowing in relation to the physical health of people with SMI.
» Outline the factors that can contribute to diagnostic overshadowing, so that you can recognise and act to prevent it.
» Consider various strategies you could use to prevent diagnostic overshadowing and therefore improve health outcomes for people with SMI.

Introduction
People with SMI, such as schizophrenia and bipolar disorder, often experience worse physical health and associated outcomes compared with the general population. For example, the prevalence of diabetes mellitus is twofold to threefold higher in people with

SMI (Holt and Mitchell 2015), and those with schizophrenia are significantly more likely to have physical health comorbidities (Smith et al 2013). This increases their risk of premature mortality; life expectancy in people with SMI is up to 10-25 years shorter than that of the general population (Fiorillo and Sartorius 2021).

The bidirectional relationship between physical and mental health is widely acknowledged, meaning that physical health issues can lead to mental illness and vice versa. However, in this article the authors focus on exploring the factors contributing to worse physical health outcomes for people with SMI.

TIME OUT 1

In your professional experience, what factors have you found can contribute to suboptimal physical health in people with SMI? Note down five factors

Physical health factors for people with severe mental illness

Physical health issues are the result of a complex interplay of several factors, which the authors will explore under three categories: effects of SMI; social determinants of health; and the healthcare system.

Effects of severe mental illness

Physical health issues are not directly caused by SMI, but may occur as a consequence of living with and managing symptoms of mental illness. For example, smoking, consuming obesogenic food, physical inactivity, substance misuse and high-risk sexual behaviours are higher among people with SMI (Firth et al 2019). While these behaviours are typically referred to as lifestyle choices, it could be argued that people with SMI often engage in them as a way to self-manage their symptoms of mental illness.

In addition, many medicines prescribed to manage symptoms of mental illness are associated with side effects that increase the risk of developing physical health issues. These include weight gain, cardiac conditions, type 2 diabetes and dyslipidaemia, as well as life-threatening side effects such as agranulocytosis and neuroleptic malignant syndrome (Nash 2018). When lifestyle factors and the side effects of medicines are combined, this further increases the risk of developing physical health conditions (Nash 2018).

Social determinants of health

Examples of the social factors influencing health, known as social determinants, include public health policies, an individual's socioeconomic status, cultural and societal norms, the environment and the availability of social support networks. The disability associated with SMI may contribute to unemployment, lower socioeconomic status, poverty and homelessness, which can subsequently lead to people with SMI living in less safe neighbourhoods, with reduced access to social and community resources, decreased access to treatment and prevention measures, and food insecurity (Liu et al 2017).

Healthcare system

Suboptimal physical health outcomes in people with SMI can be attributed to the disparity in the standard of healthcare that people with mental illness receive compared with those without mental illness (Firth et al 2019). For example, Baller et al (2015) found lipid testing for people taking antipsychotics ranged widely from 6% to 85%, while Solmi et al (2020) reported that people with SMI have lower rates of cancer screening compared with the general population. Despite higher rates of smoking, it has been identified that people with SMI receive less assistance with smoking cessation than the general population (Jackson et al 2015).

Maintaining the physical health of people with SMI requires an integration of physical and mental healthcare (Firth et al 2019). However, mental and physical healthcare services tend to operate in silos, with training and competencies of the healthcare workforce tailored to their role or specialty. Studies have shown that physical health is not a high priority for some mental health nurses (Gray and Brown 2017) and a survey of 512 service users and carers from across Australia found that the vast majority of mental health professionals did not enquire about service users' physical health (Kaine et al 2022). This may be attributed to mental health nurses lacking appropriate skills, knowledge and confidence to adequately address people's physical health needs (Jabbie et al 2024), or due to a lack of clarity regarding who is responsible for physical health monitoring (Butler et al 2020) in the absence of clear organisational guidelines.

Many people with SMI have reported that mental health nurses were too busy to address their physical health concerns (Gray and Brown 2017). The coronavirus disease 2019 (COVID-19) pandemic exacerbated the shortage of mental health nurses worldwide (International Council of Nurses 2022). Staff shortages reduce the ability of mental health nurses to provide safe, effective care that

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meets the needs of service users (Adams et al 2021), which may include physical health interventions such as screening, health promotion and education.

Stigma

Stigma negatively affects all aspects of the lives of people with SMI and can contribute to suboptimal physical health outcomes. According to Corrigan and Watson (2002), stigma comprises three components:

- Stereotypes – negative beliefs about a particular group, for example that people with SMI are 'unreliable' or 'uncooperative'.
- Prejudice – agreement with or an emotional reaction based on a stereotype, for example a mental health nurse not believing a service user's reports of a physical health symptom.
- Discrimination – behaviour based on prejudice, for example a mental health nurse not investigating a service user's symptom reports.

The effect of stigma can be twofold, with public stigma being held by members of the general population toward people with SMI and self-stigma being held by people with SMI against themselves (Corrigan and Watson 2002). Some mental health nurses may also demonstrate public stigma. For example, an Australian survey of 1,912 people with complex mental health issues found that more than 70% of respondents had experienced stigma or discrimination while accessing or receiving mental healthcare during the previous 12 months (Groot et al 2020). Experiencing stigma can result in people with SMI being reluctant to seek help (Thornicroft et al 2022).

TIME OUT 2

Think about a time when you witnessed or heard about a service user's physical health concerns being ignored or downplayed. What were the physical and emotional consequences for the service user? How do you think this experience may have affected their future help-seeking?

Diagnostic overshadowing

Diagnostic overshadowing has been referred to as a 'multidimensional experience of interconnecting contributing factors' (Molloy et al 2023) that occurs when legitimate physical health symptoms are attributed to a service user's mental health issues (Nash 2013). In diagnostic overshadowing, mental health professionals attribute physical health symptom reports and observations to symptoms of mental illness due to an implicit bias (attitudes or internalised stereotypes that unconsciously affect perceptions, actions and decisions). As a result, negative or stigmatising attitudes held at a subconscious level are activated during encounters with service users (Merino et al 2018).

Research has identified several factors related to SMI that can contribute to diagnostic overshadowing. For example, the nature of symptoms such as hallucinations, thought disorders, delusions or impaired concentration can make it challenging for service users to articulate their experiences and make themselves understood (Shefer et al 2014). This can result in challenges for healthcare professionals when history taking or eliciting details on presenting issues. Furthermore, given the interplay between physical and mental health, some people with SMI may not be able to determine, and therefore communicate, whether their experience is physical or psychological (Molloy et al 2023). There is also evidence to suggest that when healthcare professionals cannot establish the medical history of people with mental illness they may underestimate their symptoms (Björk Brämberg et al 2018). Furthermore, anticipating stigma or negative attitudes may lead people with SMI not to report physical health symptoms to healthcare professionals.

While all of these factors are associated with SMI, it is important to remember that it is not the responsibility of the person seeking help or their family and/or carers to ensure that symptom reports are taken seriously; it is the responsibility of mental health professionals.

Effects of diagnostic overshadowing on clinical decision-making

Clinical reasoning is the process by which nurses 'collect cues, process the information, come to an understanding of a patient problem or situation, plan and implement interventions, evaluate outcomes, and reflect on and learn from the process' (Levett-Jones et al 2010). This requires nurses to determine what the issue is, then decide what actions need to be taken (clinical decision-making). However, this decision-making can be impaired by implicit bias (Shah and Bohlen 2023).

Stuart et al (2012) suggested that mental health professionals tend to base their views on personal experiences with service users whom they often encounter when unwell, which can introduce bias. Relabelling physical health symptoms as manifestations of mental illness can lead to mental health nurses missing cues about service users' physical health symptoms, potentially resulting in delayed

Key points

- People with severe mental illness (SMI) often experience worse physical health and associated outcomes compared with the general population
- Stigma negatively affects all aspects of the lives of people with SMI, and can contribute to suboptimal physical health outcomes
- Diagnostic overshadowing has been referred to as a 'multidimensional experience of interconnecting contributing factors' that occurs when legitimate physical health symptoms are attributed to a service user's mental health issues
- Preventing diagnostic overshadowing involves acting in accordance with the principle of parity of esteem, whereby physical health issues are given equal priority with mental health issues

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treatment and worse physical health outcomes. Decision-making can also be affected by external factors such as a lack of resources, workload and organisational structures or processes, which McTiernan and McDonald (2015) found were occupational stressors for mental health nurses.

Table 1 shows a simple model of clinical reasoning, alongside an example of how it could be applied in practice.

Biases that can contribute to diagnostic overshadowing

Various biases may contribute to diagnostic overshadowing, including heuristics, anchoring bias, confirmation bias and fundamental attribution error.

Heuristics and anchoring bias

When making judgements, people sometimes rely on simplified information processing strategies known as heuristics, which may result in systematic, predictable errors called cognitive biases (Berthet 2022). Heuristics are general ‘rules of thumb’ or ‘decisional shortcuts’ (Whelehan et al 2020), often used by healthcare professionals to ensure efficient practice. Personal experience, intuition or an individual’s own opinions are factors that inform heuristics, but these shortcuts can lack evidence and lead to cognitive biases which may contribute to impaired clinical reasoning.

Kahneman (2011) argued that decision-making is influenced by System 1 and System 2 thinking. System 1 thinking is typically fast, automatic, effortless and intuitive. This type of thinking introduces cognitive biases, in the form of plausible judgements, that can increase the risk of suboptimal decision-making. In contrast, System 2 thinking is slower, conscious, effortful and considered, and therefore more likely to lead to better decision-making. In relation to diagnostic overshadowing, plausible judgements in System 1 thinking are heuristics that prevent mental health nurses from recognising service users’ physical health symptom reports as new information, because they associate them disproportionately with the person’s existing SMI. This is a form of anchoring bias, which occurs when healthcare professionals attach too much significance to one characteristic of a service user – as illustrated in the following case study, originally from Nash (2013) (Case study 1).

Confirmation bias

Anchoring bias often leads to confirmation bias, which occurs when people tend to seek and interpret evidence that supports their views, and to avoid potentially disconfirming evidence (Nickerson 1998). System 1 thinking contributes to confirmation bias because symptom reports are not considered in the logical and rational manner used in System 2 thinking. In diagnostic overshadowing, evidence is sought to confirm symptom reports as deriving from mental illness; for example, assessing physical health symptoms through a psychiatric lens by asking a service user questions about their concordance with their psychotropic medicines or existing symptoms of mental illness.

Fundamental attribution error

Fundamental attribution error is a form of bias that can occur when nurses or other healthcare professionals attribute service

Table 1. Simple model of clinical reasoning

Step	Description	Practice example
1. Data gathering	Clinical observations, patient self-report, visual cues, and verbal and non-verbal communication	Sam is being treated with olanzapine for somatic delusions. He reports experiencing excessive thirst (polydipsia) and needing to urinate frequently at night (nocturnal polyuria). Random testing shows his blood glucose level is 8.5mmol/L, which is above the normal range of 4.0mmol/L to 8.0mmol/L
2. Data processing	Reduce intuitive thinking by reflecting on, considering and combining the data from step 1	Sam has a high blood glucose level, polydipsia and nocturnal polyuria. Type 2 diabetes is a risk associated with olanzapine
3. Clinical judgement	Turn the data from step 2 into usable clinical information	Further investigations such as glycated haemoglobin ($HbA1_c$) and fasting blood glucose tests are needed to confirm or rule out type 2 diabetes
4. Outcome	Diagnosis and intervention based on step 3	A fasting blood glucose test confirms that Sam has type 2 diabetes. He is prescribed an oral hypoglycaemic and placed on a lifestyle programme

users' behaviours as culpable in their symptom reports, rather than investigating the symptom reports as valid. An example would be if a service user reported experiencing a persistent cough to a nurse, and the nurse said that the cough was natural due to the service user's smoking. However, a persistent cough is a common symptom of lung cancer. Attributing the cough to the person's behaviour (smoking) rather than considering other possibilities puts the service user at risk of not being investigated for lung cancer. Croskerry (2003) suggested that service users are particularly vulnerable to fundamental attribution error due to 'psych-out error', one form of which occurs when serious physical health conditions are misdiagnosed as mental health conditions.

TIME OUT 3

Unconscious bias can contribute to diagnostic overshadowing, so it is important to identify and challenge biases. Consider the following statements. Do you believe they are true? Is this based on evidence, your experiences and/or your opinions?

- 'People with SMI lack motivation to change'
- 'It is harder for people with SMI to give up smoking than it is for people in the general population'
- 'When people with delusions talk about being physically unwell it is challenging to take them seriously or believe them'
- 'It is hard to trust what people with SMI say'
- 'Engaging in physical health promotion activities with people with SMI is a waste of time'

Case study 1. Jake

At age 14 years, Jake was diagnosed with depression. He began experiencing regular headaches, dizzy spells, nausea and fatigue. These symptoms were attributed to side effects of antidepressants, even when he switched medicines. The symptoms persisted and developed into chronic headaches, neck pain, visual distortions and pulsatile tinnitus, leading to a medical review by two doctors. Both doctors informed Jake that there was nothing wrong and that his symptoms were psychosomatic. Three weeks later Jake went blind and presented to the emergency department, where he was diagnosed with idiopathic intracranial hypertension.

Jake's diagnosis of depression was the anchoring point from which plausible judgements (cognitive biases) in System 1 thinking prevented doctors from recognising his physical health symptom reports as new information. These symptom reports were viewed through a psychiatric lens (labelled psychosomatic) because the doctors anchored them to Jake's existing diagnosis of depression. However, there was a medical explanation for the symptom reports.

Strategies to prevent diagnostic overshadowing

Preventing diagnostic overshadowing involves acting in accordance with the principle of parity of esteem, whereby physical health issues are given equal priority with mental health issues (Nash 2023). Mental health nurses are well placed to reduce and challenge diagnostic overshadowing and to promote positive physical health outcomes for people with SMI. To do this they need to become aware of biases that prevent them from considering symptom reports by people with SMI as valid. Reducing diagnostic overshadowing also requires mental health nurses to improve their clinical reasoning. However, it is important to recognise the challenging environments that these nurses often work in, where a lack of staff, time and resources may mean that urgent mental health needs are prioritised over physical health issues.

Preventing diagnostic overshadowing requires mental health nurses to work differently, rather than more, and to recognise that their knowledge and skills are transferable to the context of physical health within their scope of practice. Strategies that nurses can use to prevent, recognise and challenge diagnostic overshadowing in practice include: collaboration with families and/or carers; continuing professional development (CPD); reflective practice; the therapeutic nurse-patient relationship; holistic assessment; recovery and co-production; and challenging stigma and inequality in the healthcare system.

Collaboration with families and/or carers

Preventing diagnostic overshadowing requires collaboration with, and support for, the families and carers of people with SMI. Box 1 provides a carer's perspective and guidance on avoiding diagnostic overshadowing. This comes from co-author Pauline D'Astoli, who serves as the primary caregiver for a family member with SMI. It emphasises the significance of mental health nurses partnering with carers.

TIME OUT 4

Read the carer's perspective on avoiding diagnostic overshadowing shown in Box 1.

- How could working collaboratively with carers prevent diagnostic overshadowing?
- What could you do if the person did not have a carer? How could you make your assessment comprehensive and holistic?
- Consider the advice from the carer and list three aspects of your practice that you could improve

Continuing professional development

CPD can contribute to better clinical reasoning and decision-making in the physical healthcare of people with SMI. This should focus on three main aspects: recognising and preventing bias; enhancing clinical reasoning; and improving physical health knowledge and skills.

Bias affects how nurses recognise and interpret clinical data. Targeted education to increase healthcare professionals' awareness of unconscious bias and therefore reduce its effects on service users has been recommended (Zestcott et al 2016). One approach proposed by Brand et al (2024) is co-designed simulation-based education with healthcare professionals and service users.

Levett-Jones et al (2010) outlined a clinical reasoning model to assist nurses' clinical decision-making, comprising five 'rights'. When this model is applied effectively, the nurse will be able to collect the right cues (not influenced by bias) and take the right action for the right patient at the right time and for the right reason.

By increasing their physical health knowledge and skills through CPD, mental health nurses can improve their ability to recognise symptom reports as valid. Terry and Cutter (2013) reported that nurses' knowledge and confidence increased after they attended a physical health module. Similarly, King et al (2020) found that mental health nurses' levels of confidence in managing physically deteriorating patients improved after attending a National Early Warning Score workshop. Nurses should also ensure they have up-to-date knowledge of physiological parameters and their normal ranges; for example, knowing that a blood glucose reading of 12mmol/L is high irrespective of whether the person has an SMI. It is important for nurses to identify their own learning needs in this area.

Reflective practice

Nurses can use reflection-in-action and reflection-on-action (Schön 1983) to prevent diagnostic overshadowing by enabling them to recognise when biases arise. Reflection-in-action takes place during an event or experience. The nurse should consider physical health symptom reports carefully, asking themselves 'How am I making sense of what I am seeing and hearing? Am I reframing what I see and hear as symptoms of mental illness?'

Reflection-on-action may involve the nurse discussing situations where diagnostic overshadowing has arisen, exploring how they could respond differently in the future and identifying their training needs. Clinical supervision can be a means for nurses to reflect-on-action. Reflective practice can also promote self-awareness, which is important for recognising unconscious bias.

Therapeutic nurse-patient relationship

The therapeutic nurse-patient relationship has long been considered the cornerstone of mental health nursing (Peplau 1952), and it is based on values such as empathy, trust, authenticity, genuineness, dignity and respect. There is evidence to suggest that these values are compromised in diagnostic overshadowing, with people with SMI describing not being respected, believed or trusted when reporting physical health symptoms (Molloy et al 2023). Therefore, mental health nurses need to apply the principles of the therapeutic nurse-patient relationship holistically in relation to mental and physical health issues. For example, active listening is an essential skill here because it can enable the nurse to take their time and consider symptom reports in a more logical way. This can reduce diagnostic overshadowing by enhancing clinical reasoning and reassuring service users that they are being taken seriously.

Box 1. Carer's perspective and guidance on avoiding diagnostic overshadowing

It is essential that your assessment is holistic, which means involving the service user and carer. You will need background information about the service user, who might not be able to provide this when they are unwell. As the carer, I am the only one with continuity of care and continuity of thinking. I am the case manager (unpaid). I have coordinated and attended all medical appointments and referrals for physical issues over a long period of time. I can help you see the 'bigger picture' of what is going on.

Although I carry this important information, I am often invisible to the system and those operating within it. I need you to see me as part of the team. I know what the baseline is, and I see the subtle changes, such as changes in eating patterns or ways of doing things. Often, I will notice this stuff before you do. I don't want you to dismiss me as a 'worrier,' 'overinvolved' or 'overprotective' because none of this is true. I would like you to see me as a human being. My focus is on ensuring my family member has the same standard of healthcare as I receive when I go to hospital, or the same standard of physical healthcare they would receive on a medical ward.

There are some questions you can ask and that I would like to ask you. This helps me feel supported in my role and will help you to ensure my family member's history of severe mental illness does not overshadow their physical health concerns. Please reassure me that my concerns will be promptly escalated to an appropriate healthcare professional and that I can promptly receive a second opinion internally. I want you to ask me:

- What are you seeing that's a change?
- Why are you worried?
- What would you like me to do?
- What have we missed?
- What's been happening with their physical health lately?

When I notice deterioration in their physical or mental health, I want you to be able to answer:

- Who do I talk to? Who will listen to me?
- What is the care plan?
- What investigations are you going to do?
- How do I escalate my concerns?

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Developing a therapeutic nurse-patient relationship can also enhance person-centred care. This relationship is particularly important for people who have previously experienced diagnostic overshadowing, to identify how their physical health condition is progressing so that its management and outcomes can be optimised, for example by addressing treatment side effects or any complications that have arisen.

Holistic assessment

The risk factors for suboptimal physical health in SMI are multifactorial and include social and health inequalities, deprivation, poverty, exclusion and stigma. Combined with factors such as side effects of medicines and increased exposure to behavioural risk factors such as smoking and suboptimal diet, it becomes clear that a holistic, person-centred approach to physical health assessment is necessary. However, service users often report having their physical health and mental health assessed and treated separately (Nash 2014), which runs counter to the concept of holistic care. Mental health nurses can promote holistic care by using their range of skills and working with the multidisciplinary team to meet service users' needs.

Recovery and co-production

Little is known about the relationship between suboptimal physical health and mental health recovery. However, the principles of recovery-oriented practice (such as person-centred care, holism and empowerment) and co-production are equally important for physical health issues, especially giving people hope that they can live a fulfilling life with a comorbid physical health condition. Co-production is a process where professionals and service users share power in the planning and delivery of support to improve the quality of life for people and communities (Slay and Stephens 2013).

Challenging stigma and inequality in the healthcare system

Improving physical health and associated outcomes in people with SMI is a matter of social justice and fairness, so mental health nurses need to advocate for the right to equal treatment for people with SMI (Nash 2023). Mental health nurses should also raise their personal awareness and understanding of stigma in the healthcare system and challenge it accordingly.

Conclusion

People with SMI tend to experience worse physical health and associated outcomes compared with the general population. Mental health nurses are well positioned to improve physical health outcomes for people with SMI; however, they need to be aware that diagnostic overshadowing is a significant risk. It is important that mental health nurses can recognise diagnostic overshadowing, understand how and why it occurs, and implement various strategies to prevent it.

TIME OUT 5

Identify how being aware of, understanding and preventing diagnostic overshadowing applies to your practice and the requirements of your regulatory body

TIME OUT 6

Undertaking this CPD article can be used as evidence for revalidation, or the equivalent in the country where you work. Now that you have completed it, reflect on your practice in this area and consider writing a reflective account. Guidelines are available at **rcni.com/reflective-account**

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References

Adams R, Ryan T, Wood, E (2021) Understanding the factors that affect retention within the mental health nursing workforce: a systematic review and thematic synthesis. International Journal of Mental Health Nursing. 30, 6, 1476-1497. doi: 10.1111/inm.12904

Baller JB, McGinty EE, Azrin ST et al (2015) Screening for cardiovascular risk factors in adults with serious mental illness: a review of the evidence. BMC Psychiatry. 15, 55. doi: 10.1186/s12888-015-0416-y

Berthet V (2022) The impact of cognitive biases on professionals' decision-making: a review of four occupational areas. Frontiers in Psychology. 12, 802439. doi: 10.3389/fpsyg.2021.802439

Björk Brämberg E, Torgerson J, Norman Kjellström A et al (2018) Access to primary and specialized somatic health care for persons with severe mental illness: a qualitative study of perceived barriers and facilitators in Swedish health care. BMC Family Practice. 19, 1, 12. doi: 10.1186/s12875-017-0687-0

Brand G, Bonnamy J, Dix S et al (2024) 'You don't see what I see': co-designing simulation to uncover and address cognitive bias in healthcare. Medical Teacher. 1-4. doi: 10.1080/0142159X.2024.2313581

Butler J, de Cassan S, Turner P et al (2020) Attitudes to physical healthcare in severe mental illness; a patient and mental health clinician qualitative interview study. BMC Family Practice. 21, 1, 243. doi: 10.1186/s12875-020-01316-5

Corrigan PW, Watson AC (2002) Understanding the impact of stigma on people with mental illness. World Psychiatry. 1, 1, 16-20.

Croskerry P (2003) The importance of cognitive errors in diagnosis and strategies to minimize them. Academic Medicine. 78, 8, 775-780. doi: 10.1097/00001888-200308000-00003

Fiorillo A, Sartorius N (2021) Mortality gap and physical comorbidity of people with severe mental disorders: the public health scandal. Annals of General Psychiatry. 20, 1, 52. doi: 10.1186/s12991-021-00374-y

Firth J, Siddiqi N, Koyanagi A et al (2019) The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. The Lancet Psychiatry. 6, 8, 675-712. doi: 10.1016/s2215-0366(19)30132-4

Gray R, Brown E (2017) What does mental health nursing contribute to improving the physical health of service users with severe mental illness? A thematic analysis. International Journal of Mental Health Nursing. 26, 1, 32-40. doi: 10.1111/inm.12296

Groot C, Rehm I, Andrews C et al (2020) Report on Findings from the Our Turn to Speak Survey: Understanding the Impact of Stigma and Discrimination on People Living with Complex Mental Health Issues. nationalstigmareportcard.com.au/sites/default/files/2021-06/NSRC_Full_Report.pdf (Last accessed: 5 June 2024.)

Holt RI, Mitchell AJ (2015) Diabetes mellitus and severe mental illness: mechanisms and clinical implications. Nature Reviews Endocrinology. 11, 2, 79-89. doi: 10.1038/nrendo.2014.203

International Council of Nurses (2022) The Global Mental Health Nursing Workforce: Time to Prioritize and Invest in Mental Health and Wellbeing. www.icn.ch/sites/default/files/2023-04/ICN_Mental_Health_Workforce_report_EN_web.pdf (Last accessed: 5 June 2024.)

Jabbie L, Walshe C, Ahmed F (2024) The views and perceptions of training in physical health care amongst mental health nurses, managers of mental health nurses and trainers: a systematically constructed narrative synthesis. International Journal of Mental Health Nursing. 33, 2, 309-323. doi: 10.1111/inm.13253

Jackson JG, Diaz FJ, Lopez L et al (2015) A combined analysis of worldwide studies demonstrates an association between bipolar disorder and tobacco smoking behaviors in adults. Bipolar Disorders. 17, 6, 575-597. doi: 10.1111/bdi.12319

Kahneman D (2011) Thinking, Fast and Slow. Farrar, Straus and Giroux, New York NY.

Kaine C, Lawn S, Roberts R et al (2022) Review of Physical and Mental Health Care in Australia. Lived Experience Australia Ltd, Marden SA.

King M, Keogh B, Donohue G (2020) Evaluating mental health nurses' confidence in recognising a physically deteriorating patient. Mental Health Practice. 24, 5, 28-33. doi: 10.7748/mhp.2020.e1519

Levett-Jones T, Hoffman K, Dempsey J et al (2010) The 'five rights' of clinical reasoning: an educational model to enhance nursing students' ability to identify and manage clinically 'at risk' patients. Nurse Education Today. 30, 6, 515-520. doi: 10.1016/j.nedt.2009.10.020

Liu N, Daumit GL, Dua T et al (2017) Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. World Psychiatry. 16, 1, 30-40. doi: 10.1002/wps.20384

McTiernan K, McDonald N (2015) Occupational stressors, burnout and coping strategies between hospital and community psychiatric nurses in a Dublin region. Journal of Psychiatric and Mental Health Nursing. 22, 3, 208-218. doi: 10.1111/jpm.12170

Merino Y, Adams L, Hall WJ (2018) Implicit bias and mental health professionals: priorities and directions for research. Psychiatric Services. 69, 6, 723-725. doi: 10.1176/appi.ps.201700294

Molloy R, Brand G, Munro I et al (2023) Seeing the complete picture: a systematic review of mental health consumer and health professional experiences of diagnostic overshadowing. Journal of Clinical Nursing. 32, 9-10, 1662-1673. doi: 10.1111/jocn.16151

Nash M (2013) Diagnostic overshadowing: a potential barrier to physical health care for mental health service users. Mental Health Practice. 17, 4, 22-26. doi: 10.7748/mhp2013.12.17.4.22.e862

Nash M (2014) Mental health service users' experiences of diabetes care by mental health nurses: an exploratory study. Journal of Psychiatric and Mental Health Nursing. 21, 8, 715-723. doi: 10.1111/jpm.12140

Nash M (2018) The physical health of people with mental health problems. In Norman I, Ryrie I (Eds) The Art and Science of Mental Health Nursing: Principles and Practice. Fourth edition. Open University Press, London, 626-644.

Nash M (2023) Parity of esteem can be achieved with a shift in attitudes. Mental Health Practice. 26, 5, 5. doi: 10.7748/mhp.26.5.5.s1

Nickerson RS (1998) Confirmation bias: a ubiquitous phenomenon in many guises. Review of General Psychology. 2, 2, 175-220. doi: 10.1037/1089-2680.2.2.175

Peplau HE (1952) Interpersonal Relations in Nursing. GP Putnam's Sons, New York NY.

Schön D (1983) The Reflective Practitioner: How Professionals Think in Action. Basic Books, New York NY.

Shah HS, Bohlen J (2023) Implicit Bias. StatPearls Publishing, Treasure Island FL.

Shefer G, Henderson C, Howard LM et al (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, 11, e111682. doi: 10.1371/journal.pone.0111682

Slay J, Stephens L (2013) Co-Production in Mental Health: A Literature Review. New Economics Foundation, London.

Smith DJ, Langan J, McLean G et al (2013) Schizophrenia is associated with excess multiple physical-health comorbidities but low levels of recorded cardiovascular disease in primary care: cross-sectional study. BMJ Open. 3, 4, e002808. doi: 10.1136/bmjopen-2013-002808

Solmi M, Firth J, Miola A et al (2020) Disparities in cancer screening in people with mental illness across the world versus the general population: prevalence and comparative meta-analysis including 4 717 839 people. The Lancet Psychiatry. 7, 1, 52-63. doi: 10.1016/S2215-0366(19)30414-6

Stuart H, Arboleda-Florez J, Sartorius N (2012) Paradigms Lost: Fighting Stigma and the Lessons Learned. Oxford University Press, Oxford.

Terry J, Cutter J (2013) Does education improve mental health practitioners' confidence in meeting the physical health needs of mental health service users? A mixed methods pilot study. Issues in Mental Health Nursing. 34, 4, 249-255. doi: 10.3109/01612840.2012.740768

Thornicroft G, Sunkel C, Aliev AA et al (2022) The Lancet Commission on ending stigma and discrimination in mental health. The Lancet. 400, 10361, 1438-1480. doi: 10.1016/S0140-6736(22)01470-2

Whelehan DF, Conlon KC, Ridgway PF (2020) Medicine and heuristics: cognitive biases and medical decision-making. Irish Journal of Medical Science. 189, 4, 1477-1484. doi: 10.1007/s11845-020-02235-1

Zestcott CA, Blair IV, Stone J (2016) Examining the presence, consequences, and reduction of implicit bias in health care: a narrative review. Group Processes & Intergroup Relations. 19, 4, 528-542. doi: 10.1177/1368430216642029

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FOR NURSES INVOLVED IN MENTAL HEALTH CARE
Mental Health Practice

RCNi

Diagnostic overshadowing

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. Which statement is false?

a) Physical health issues may occur as a consequence of living with and managing symptoms of mental illness ☐
b) People with severe mental illness (SMI) are at increased risk of premature mortality ☐
c) The relationship between physical and mental health is unidirectional ☐
d) There is a disparity in the standard of healthcare people with mental illness receive compared with those without mental illness ☐

2. Which of these is not considered a social determinant of health?

a) Socioeconomic status ☐
b) Treatment side effects ☐
c) Cultural and societal norms ☐
d) Public health policies ☐

3. Discrimination is defined as:

a) Negative beliefs about a particular group ☐
b) An emotional reaction based on a stereotype ☐
c) Behaviour based on prejudice ☐
d) Attitudes or internalised stereotypes that unconsciously affect perceptions ☐

4. Diagnostic overshadowing occurs when:

a) Different healthcare professionals give a service user conflicting diagnoses ☐
b) Legitimate physical health symptoms are attributed to a service user's mental illness ☐
c) A service user experiences multiple physical health issues with no clear cause ☐
d) A service user makes a self-diagnosis based on information they have read online ☐

5. Which of the following factors can contribute to diagnostic overshadowing?

a) Service users may be unable to make themselves understood ☐
b) People with SMI may be unable to communicate whether their experience is physical or psychological ☐
c) Healthcare professionals who cannot establish medical history of people with mental illness may underestimate their symptoms ☐
d) All of the above ☐

6. What are heuristics?

a) General 'rules of thumb' or 'decisional shortcuts' ☐
b) Human factors that influence how people interact with products, equipment, environments and systems ☐
c) The policies, procedures and clinical guidelines that healthcare professionals must adhere to ☐
d) Workplace factors that may prevent nurses from performing their role effectively ☐

7. Healthcare professionals attaching too much significance to one characteristic of a service user is a form of:

a) Authority bias ☐
b) Anchoring bias ☐
c) Sampling bias ☐
d) Recall bias ☐

8. Which statement is false? According to Kahneman:

a) Decision-making is influenced by System 1 and System 2 thinking ☐
b) System 1 thinking is typically fast, automatic, effortless and intuitive ☐
c) System 2 thinking is slower, conscious, effortful and considered ☐
d) System 2 thinking introduces cognitive biases that can increase the risk of suboptimal decision-making ☐

9. In confirmation bias, people will:

a) Seek and interpret evidence that supports their views, and avoid potentially disconfirming evidence ☐
b) Attempt to delegitimise and discredit the views of others ☐
c) Ask others if their views are correct ☐
d) Attack the characteristics and perceived motives of people with differing views to themselves ☐

10. How can mental health nurses prevent diagnostic overshadowing?

a) By acting in accordance with the principle of parity of esteem ☐
b) By becoming aware of biases ☐
c) By improving their clinical reasoning ☐
d) All of the above ☐

How to complete this assessment

This multiple-choice quiz will help you test your knowledge. It comprises ten multiple choice questions broadly linked to the previous article. There is one correct answer to each question.

You can read the article before answering the questions or attempt the questions first, then read the article and see if you would answer them differently.

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This multiple-choice quiz was compiled by **Alex Bainbridge**

The answers to this quiz are::

1. c 2. b 3. c 4. b 5. d 6. a
7. b 8. d 9. a 10. d

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This activity has taken me __ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

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