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Avoiding the Overdiagnosis of Bipolar Disorder in Correctional Populations

by Melissa S. Caldwell

Abstract

Correctional health care providers should be conscious of the dangers of labeling patients with a severe mental illness such as bipolar disorder that is based more on impressions than adequate evidence. Key factors include a firm grounding in the phenomenology of genuine mental illness and a willingness to invest resources to buy time toward an accurate diagnosis. In doing so, practitioners actually preserve resources while gaining confidence that patients are being cared for correctly. Although diagnostic certainty can be challenging, correctional practitioners can avoid the pitfalls of overdiagnosis and improve the state of care not only in the correctional setting, but also in the community at large. Likely causes of overdiagnosis include practitioners' interviewing styles, use of incomplete data, emphasis on certain symptoms, and neglect of important time frames.

Key Words: Mental illness, treatment, bi-polar disorders, diagnostic accuracy, overdiagnosis, cognitive behavioral therapy, diagnostic sloppiness, interviewing styles.

Introduction

Even with a growing body of research and the greater availability as well as advancement of diagnostic tools, the nature of mental illness and its treatment still presents as an enigma not only for society, but even for the practitioner. Such is the situation with bipolar disorder and its variants (e.g., Bipolar I, Bipolar II, Cyclothymic Disorder), which

have long posed diagnostic and treatment challenges for practitioners. Treatment providers are invested in providing effective interventions for afflicted patients, recognizing that untreated bipolar disorder has pervasive personal consequences, such as damaging relationships, impairing educational and occupational productivity, and being associated with a greater risk for suicide.

Diagnostic Trends

Historically, the main concern has been the failure to identify bipolar disorder, thus denying patients the care they need for their emotional stability and overall welfare (Bowden, 2001; Katzo, Hsu, and Ghaemi, 2003). Recent studies have suggested that the pendulum has swung such that the trend is now towards overdiagnosis rather than underdiagnosis. Moreno et al. (2007) found through a review of physician office visits that the number of adults being diagnosed with a bipolar disorder almost doubled over the last decade. In youth below the age of 19, a 40-fold increase in the diagnosis was found. As suggested by the authors, these findings highlight the need for further study to determine the accuracy of clinical diagnoses of child and adolescent bipolar disorder in community practice. One such review of 700 patients' diagnostic profiles found that over one-half (57%) were wrongly assigned the diagnosis of bipolar disorder (Zimmerman et al., 2008).

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In this article, I discuss the implications of this reversal of trends for the treatment of incarcerated patients in correctional settings. As a disclaimer, my intent is not to suggest that the problem of misdiagnosis of bipolar disorder is now solely one of overdiagnosis. Compelling evidence still exists that some patients are being underdiagnosed (e.g., Hirschfield et. al., 2005; Zimmerman et. al., 2008). However, the purpose of this article is to highlight the potential causes and contributing factors of overdiagnosis, as well as the consequences of false positives among correctional populations.

Diagnostic Accuracy

The overriding goal for mental health treatment providers, whether in community or secure settings such as jails or prisons, is to ensure that patients are provided with appropriate and effective treatment given their diagnostic presentation. Treatment of mental health conditions may include medication, as well as non-pharmacologic, psychotherapeutic or behavioral interventions. Each treatment comes with its own unique set of benefits and drawbacks. What is critical is achieving diagnostic accuracy such that the appropriate intervention is selected.

How do health care providers react when they learn that a patient was prescribed insulin without a diagnosis of diabetes? What consequences could this pose to the patient's health? Injury, even death? The health care profession has shown increased awareness of the negative effects of treatment without diagnostic certainty. In recent years, for example, a movement has emerged to limit the prescribing of antibiotics in cases where there is no evidence of bacterial infection. This is a change from times past when it was common for patients with cold symptoms to be prescribed antibiotics despite the awareness that the symptoms were likely the cause of a virus that would not remit with the selected pharmacologic treatment. The treatment mentality seemed to suggest a greater professional comfort with providing a pharmacologic treatment rather than other less-invasive interventions (e.g., counseling the patient on self-care such as greater fluid intake and rest). In short, it is better to treat with a tangible intervention (i.e., a pill) than to leave the patient with the perception that no treatment has been provided. In such cases, change came as a result of the development of antibiotic-resistant strains of bacteria and the recognition that well-intentioned prescribing habits had served as contributing factors (Gonzales, Steiner, & Sande, 1997). Albeit less dramatic in some respects but of no less importance are the effects of prescribing medica-

tions for the treatment of bipolar disorder without diagnostic certainty.

Correctional Challenges

Correctional settings, through the combined effect of numerous societal factors (e.g., deinstitutionalization, changes in legislation, reduction in community funding for the treatment of the mentally ill) are increasingly being assigned the responsibilities of identifying and caring for individuals with mental health and/or behavioral problems. One recent review found that in the United States there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals (Torrey et al., 2010). Of particular note is the observation that as the number of hospital beds for the mentally ill continues to fall, the correctional population continues to grow. Thus, what was once viewed as a case of deinstitutionalization has become one of transinstitutionalization, with the nation's jails and prisons becoming the primary setting for the treatment of the mentally ill. This is a phenomenon that has gotten increased recognition in recent years. What has not received as much notice is the exacerbating role of misdiagnosis in the realm of correctional mental health services.

Although only conjecture at this point, current research findings demonstrating the increased diagnosis of bipolar disorder in children and young adults (Moreno et. al., 2007) have significant implications for correctional populations. According to Bureau of Justice Statistics, individuals who are incarcerated in jails and prisons are disproportionately of the late adolescent-early adult age range. Thus, it is probable that the individuals who are acquiring, albeit inaccurately, the diagnosis of bipolar disorder will be overrepresented in correctional settings.

As correctional mental health providers, my colleagues and I have seen both an increase in acute mental illness and the frequent scenario of a detainee who reports a past diagnosis of bipolar disorder without the necessary symptom profile. Specifically, they report no history of mania or hypomania and are exhibiting no current signs. Review of treatment records, when they can be obtained, frequently demonstrate the prescribing of medications such as mood stabilizers, antipsychotics, and sedating agents with only provisional diagnosis or incomplete diagnosis (e.g., without sufficient symptom timeframes met).

This aforementioned scenario places the correctional treat-

ment provider in a position of discomfort. Driving this is the recognition that bipolar disorder is often episodic with periods of remission. Additionally, medication may be used for maintenance of remission to prevent relapse. Thus, the physician is faced with the difficult decision of whether to treat or not to treat: to prescribe medication and possibly perpetuate incorrect treatment based on a flawed diagnosis, or to not prescribe and risk the patient becoming acutely ill with the disorder is present but only dormant.

Overdiagnosis of bipolar disorder has significant implications for the welfare of patients and profound consequences for correctional settings and society as a whole. As mentioned previously, the damaging effects of untreated bipolar disorder are without question. This disorder impairs personal identity, relationships, and the ability to function as a productive member of society. However, being misdiagnosed with bipolar disorder may have just as significant an impact on people's capacity for their health and ability to function. For the individual, being erroneously diagnosed with bipolar disorder may lead to the stigmatization of having a serious, possibly lifelong mental illness. For many wrongly diagnosed individuals, the mechanism of damage is theorized to be disempowerment through the effect of labeling. Application of the label of "bipolar disorder," for example, may lessen the patient's perceived responsibility to maintain health or appropriate conduct due to the disease. Patients may develop an external locus of control believing that their emotions and conduct can only be moderated by the effect of external factors such as medication.

This is particularly problematic as a significant percentage of incarcerated individuals present with substance abuse (Fazel, Bains, and Doll, 2006). This highlights the importance of ensuring that correctional patients are being treated appropriately based on clinical indications so as not to contribute to substance abuse or other unhealthy coping strategies. In correctional settings, where personal accountability is a frequent focus of intervention, being labeled as having a severe and persistent mental illness may be a significant detractor from rehabilitation. Clients may believe that they cannot be viewed as culpable for poor decisions (such as drug use, irresponsibility, or criminality) because they are "mentally ill."

From a treatment standpoint, misdiagnosis leads not only to improper treatment (e.g., potential of over or mis-prescribing medications with little empirical evidence of efficacy), but also a failure to provide the patient with appropriate interventions. There is a tendency to become over-focused on medications

and to minimize the non-pharmacologic interventions such as cognitive behavioral therapy. There is increased argument that this is the case for patients with borderline personality disorder (a disorder whose criterion of affective instability may be mistaken for the polar shifts in mood that characterize bipolar disorder). For such patients, interventions such as dialectical behavioral therapy have been shown to have significant efficacy (Linehan et al, 1999). When misdiagnosed with bipolar disorder, they are unlikely to be afforded such interventions and instead they are unnecessarily exposed to medication and all of its powerful side effects (e.g., endocrine, renal, hepatic, immunological, metabolic effects).

For the correctional system and society, the negative effects of overdiagnosis of bipolar disorder likely mirror those for the individual. As such, one must recognize the role that incorrect diagnoses and inappropriate treatments, such as the unnecessary prescribing of medications, have for such societal ills as substance abuse and criminal recidivism. Additionally, resources available to care for people with mental health problems, whether in the community or in a correctional setting, are not unlimited. Caution is necessary so that medical, mental health, and correctional systems are not unduly drained of resources (time, energy, and supplies).

Over the last several decades, practitioners have been warned about the effects of underdiagnosis. The main argument being that individuals with bipolar disorder, through a failure to diagnose and treat, would be deprived of the care they need. The irony is that now, through a shift to the other extreme (i.e., pervasive overdiagnosis), the genuinely ill may be denied the care they require as result of an exhaustion of resources.

Likely Culprits of Overdiagnosis

There is much conjecture and discussion about the causes of misdiagnosis, in general, and the overdiagnosis of bipolar disorder in particular. Potential contributing factors include styles of interviewing patients and the sources of data practitioners use for their diagnoses. In cases of overdiagnosis, some have suggested that there is culpability in the tendency of practitioners to adopt a diagnostic interviewing style that takes on the form of a generalized conversation (Sachs, 2008) rather than using structured interviewing derived from the

DSM-IV-TR (2000). Likewise, the tendency to use a more superficial history rather than supplementing self-reported information with other data (e.g., observations of family or care providers) may lead to snap judgments. The use of leading questions (about “racing thoughts,” for example) instead of open-ended questioning and patients’ idiosyncratic interpretations of such questions may also lead to an overendorsement of symptoms suggestive of bipolar disorder.

Beyond the interview styles of practitioners, a failure to consider all of criteria and necessary timeframes (e.g., week long duration of mania, two-week duration of major depressive episode in Bipolar II) is another likely culprit of misdiagnosis. Also, practitioners may overemphasize the importance of certain symptoms being present without considering the overall symptom profile. Patients with anxiety, agitation, irritability, and restlessness that do not persist are sometimes misdiagnosed with bipolar disorder. These could be symptoms of bipolar disorder but must be accompanied by other criteria, such as hyperactivity, feeling energetic despite just a few hours of sleep, or inflated self-esteem. Other potential causes of misdiagnosis related to diagnostic interviewing include: overdependence on subjective report or historical diagnosis (due to time pressure) which may be subject to error and a failure to consider other diagnoses which may have similar symptom presentations (e.g., Borderline Personality Disorder).

Researchers such as Zimmerman (2010) suggest the import of contributing factors beyond what might be characterized as diagnostic sloppiness. Specifically, they point to the tendency of clinicians to make a medication-responsive diagnosis, such as bipolar disorder, than one that relies on psychotherapy such as borderline personality disorder. Additionally, accompanying this bias is the fact that compared to years past, there are now an unprecedented number of drugs purported to treat bipolar disorder. Adding to this are the efforts of pharmaceutical companies to advertise the utility and effectiveness of such medications to not only practitioners but also the public. Pharmaceutical advertising has become a notable part of popular culture with depictions of mental illness in forums such as magazines and television. Zimmerman (2010) has gone so far as to suggest that training initiatives intended to improve detection of the disorder may also be responsible for overdiagno-

sis. This suggests the role of a confirmatory bias in which practitioners, primed to look for symptoms of bipolar disorder, are biased to attend only to symptoms or patient reports that suggest the presence of the condition.

Avoiding the Pitfalls of Overdiagnosis in a Correctional Settings

Drawing from the literature and the experience of correctional practitioners, the following is a sampling of tips to prevent the misdiagnosis of bipolar disorder in correctional populations. First, caution must be exercised when attempting to diagnose substance-abusing patients, particularly when mood instability co-occurs with stimulant use. This is particularly relevant for patients who report a past diagnosis or the presence of symptoms during a similar time frame as substance use. While it is true that substance use has a high co-occurrence for individuals with bipolar disorder, it is also true that individuals may present with symptoms that mimic a manic episode when actively using such mind-altering substances. It is not unheard of for detainees to report they were using drugs such as cocaine or methamphetamine, but the community practitioners from whom the diagnosis originated were not aware of their patients’ use of such stimulants.

A second consideration is the importance of subjective reports. Self-reports should never be considered in isolation of more objective behavioral data (e.g., front-line staff reports). This is not only because of questions of credibility, but also because patients may not be the best judge of their behavior. An individual may report “racing thoughts,” but the behavioral presentation is more consistent with anxiety rather than mania.

Thirdly, history is important but not more so than current presentation. Experience has shown the consequences associated with accepting and perpetuating erroneous diagnosis. And finally, make sure that treatment fits the diagnosis and always take care that there is a diagnosis before there is treatment.

Advantages of the Correctional Setting

Correctional settings should not be the intended venues for the care of people with severe and persistent mental illness. However, reality dictates recognition that the trend towards incarcerating

mentally ill persons is not likely to abate in the near future. Therefore, the correctional professional is faced with two options: to sit by despite the fact that correctional settings are seeing more and more acute mental health issues in their populations or to become equipped to treat this population in the most effective and humane fashion.

Correctional facilities, although not traditionally viewed as such, are inpatient settings, which translates into greater control of patient behavior. Unlike in most community settings, the structure and control of jails or prisons can prevent patients from accessing substances such as drugs and other stimulants that alter their mental state. Thus, correctional settings have an advantage in that they enable practitioners to obtain a baseline of behavior that may not be possible in an out-patient, community-based setting.

Correctional settings also generally have the availability of around-the-clock behavioral logging of patient behavior. As such, a wealth of data is available to practitioners to tease apart patient presentations from other diagnoses that are often mistaken for bipolar disorder, as well as presentations that do not constitute a psychiatric diagnosis (e.g., malingering). The availability of precautions to ensure patient safety during that observation period (e.g., modifications of property, cell placement, restraint if necessary) also facilitates the safe collection of behavioral data. Thus, correctional settings properly staffed with mental health professionals are generally well-equipped to increase diagnostic accuracy while reducing patient risks. When these resources are properly implemented, correctional practitioners are less subject to pressures to “leap before looking” (i.e., diagnose and treat without adequate observation and data collection).

Conclusion

As with most things in life, the easy way is not likely to be the right way. In correctional health care, it is important to be conscious of the dangers of labeling patients with a severe mental illness such as bipolar disorder without adequate evidence, based largely on impression. The key lies in a firm grounding in the phenomenology of genuine mental illness and a willingness to invest resources to buy time toward an accurate diagnosis. In doing so, practitioners actually preserve resources while gaining confidence that patients are being cared for in the correct

fashion. Although challenged by the difficulties of achieving diagnostic certainty, the correctional practitioners are in a position to avoid the pitfalls of overdiagnosis and to improve the state of care not only in correctional settings, but also in the community at large.

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