Borrowing from the Cutting Edge: Using Diagnostic & Treatment Advantages to Optimize Outcomes

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Diagnosis

- The Diagnostic Four-Step in Examination
  - Acquisition of facts
  - Evaluation of facts
  - Listing of hypotheses
  - Choosing between hypotheses

(Bedside Diagnostic Examination, DeGowin & DeGowin, 1976)
Diagnosis

• Life is short; art is long; opportunity fugitive; experience delusive; judgment difficult. It is the duty of the physician not only to do that which immediately belongs to him, but likewise to secure the cooperation of the sick, of those who are in attendance, and of all the external agents.

(Hippocrates, The Aphorisms, 514)
Diagnosis

• For most psychiatric conditions there are no explanations. “Etiology unknown” is the hallmark of psychiatry as well as its bane.

(Goodwin DW, Guze, Psychiatric Diagnosis, Fifth Edition, 1996)
Validating Criteria for Psychiatric Diagnosis

- Clinical Description
- Delimitation from Other Disorders
- Course of Illness
- Familial pattern
- Laboratory features (ex. Pharmacogenetic assays)

(Robins LN, Barrett JE, The Validity of Psychiatric Diagnosis, 1989)
The Usefulness of the 5 Axes

- Provides for delineation of acute, so-called primary diagnosis
- Incorporates consideration of personality
- Includes stressors and psychology
- Considers impact non-psychiatric illnesses
- Allows for impression of illness severity
Structured Clinical Interview

• When rigorously conducted (and with consideration of all other records), greatly reduces variance in diagnosis among providers (kappa scores of ~0.8)
• Forces systematic inquiry about all psychiatric illnesses (prevents omission errors)
• Superior to self-report instruments because of clinical observations and less vulnerable to lack of insight
Co-morbidity

- Is the rule, not the exception
- Requires systematic assessment for all psychiatric disorders, medical illnesses, and attention to “V” codes
### National Comorbidity Survey

<table>
<thead>
<tr>
<th># Lifetime DSM-III Disorders</th>
<th>% General Population*</th>
<th>% Sample With BP I†</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>≥ 3</td>
<td>14</td>
<td>96</td>
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</tbody>
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Clinical Diagnostic Assessment

- Clinical interview, assessment and ongoing treatment by clinicians with dedicated time to Sibcy and Williams House programs:
  - Psychiatrist
  - Psychologist
  - Social worker
  - Nurse
  - Expressive therapist
  - Nutritionist
  - Neuropsychological and Psychological testing
Clinical Diagnostic Assessment

- Internal Medicine assessment
- Neurology assessment
- Infectious Disease assessment
- Brain MRI
- PANS/PANDAS testing
Individualized Treatment

- Consultations and treatment programs with specialized expertise, e.g., OCD, Addictions, Mood Disorders, Psychosis, Eating Disorders
- Evidenced-based treatment with medications, individual, group and milieu therapies
- DBT and CBT skills are woven into treatment
- Additional therapies include Motivational Interviewing, ERP, supportive therapy, and psychoeducational family sessions
- Availability of ECT, TMS, and innovative treatments through clinical trials at Research Institute
Individualized Treatment

- Yoga and fitness
- Life Skills Coach
- Spiritual Care Coordinator
Borrowing from The Cutting Edge

- Novel mechanisms for treatment-refractory depression: NMDAR receptor modulator; Vasopressin 1b agonist
- Novel diagnostic studies (searching for a biomarker): Proteomic assays of 9 serum proteins; Medibio Depression Diagnostic Aid (autonomic dysfunction in MDD)
- GLP-1 peptide analogue for co-morbid obesity, and for binge eating disorder
- TMS for OCD
Blue Print for Recovery

• Feedback session at completion of Clinical Diagnostic Assessment
  • Patient, family, treatment team meet to review integrated findings
  • Provide further treatment recommendations and referral options
Question & Answer

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