DMR*Dynamics* **David M. Reiss, M.D.**

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Direct Phone: 262.477.9242
(262 4PSYCH2)
San Diego Office:
619.280.3422
Fax: 619.280.3406

DMREISS@GMAIL.COM
WWW.DMRDYNAMICS.COM

Mailing Address:
P.O. Box 9684
Rancho Santa Fe, CA
92067-4684

Street Delivery Address:
12395 El Camino Real, #305
San Diego, CA 92130

EVIDENCE-BASED UNCERTAINTY:

The KNOWN UNKNOWNS

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Synopsis:

- The foundation of "Evidence-Based Medicine" (EBM) is the assumption that the determination of effective and efficient medical treatment protocols must be based upon "evidence" that consists of the accepted conclusions of formal studies and clinical trials which are controlled and peer-reviewed and that are driven by symptomatology and diagnoses.

- Treating psychiatric conditions is much more complex and is not amenable to a linear decision-making process.

    - Reponses to mental health treatment are impacted by multiple interdependent variables that are not explicitly identified by describing symptomatology and using standard diagnostic nosology.

    - It may be proposed that based upon a comprehensive evaluation, experienced clinicians implicitly take into account a multitude of variables in devising a case formulation and mental health treatment strategy, above and beyond what can be established simply by providing a diagnosis. However, measuring and testing that hypothesis is problematic.

        - That is, arguing by presentation of clinical experience or theoretical knowledge is held in low regard if not accompanied by quantifiable studies.

- Addressing this issue through formal study is paradoxical in that the premise being proposed is that describing the complexity of the provision of comprehensive mental health treatment does not lend itself to typical controlled and/or statistical studies relating diagnostic variables to cost-effectiveness – but that particular method of study is currently so entrenched that in order to have any impact, it is necessary to offer opinions supported by that very type of statistical study.

I have attempted to devise an approach which uses the current standards of statistical research to evaluate whether or not, paradoxically, those standards are not appropriate to devising protocols for mental health treatment.

- I propose investigating a relatively small number of variables that are not directly related to symptomatology and diagnosis, and determining statistically whether those variables can be correlated with prevalence of mental illness, duration of disability due to mental illness, and one specific aspect of mental health treatment (the number of psychotropic medications prescribed to a patient)
    - **That is, evaluating variables that can be easily "known" but that are "unknown" and not considered by current EBM criteria.**
- The data base to be used would be the personal histories I have available from performing California Workers Compensation evaluations of "stress claims" (claims of industrially-related psychiatric injury).
- The contributory variables I have chosen are neither inherently psychodynamic nor inherently biophysiological – arguments can be made that they are either or both. The advantage of choosing these variables is that it avoids having to address specific etiology, be it psychodynamic or biophysiological, and therefore the study cannot be considered "biased" by either point of view.
- The outcome variables I have chosen have direct implications regarding cost-effectiveness.
    - If this pilot study bears out that typically ignored ("unknown") contributory variables can be correlated with cost–effectiveness, this paves the way for further study establishing that EBM, as currently practiced, will only be a rough and inaccurate manner of providing cost effective mental health treatment guidelines unless the impact of these variables can be taken into consideration.
- Within my practice, I have noted that what appears to be an unusually high percentage of Workers Compensation claimants are status post bariatric surgery (recently or remote). This is not only so in cases where one might draw a direct correlation between weight

and injury (e.g., depression secondary to knee or back injuries) but I believe this to be the case even in claims which have no direct correlation at all with weight and in which the claimant makes no claim that his or her weight or bariatric surgery in any manner impacted the situation at work; such as typical “stress” claims related to interpersonal issues, harassment, workplace demands, general workplace “stress”, etc.

- I have noted that an unusually high percentage of claimants have a parent who has suffered a significant (over six months) period of disability (physical or mental) during their productive work years (not simply related to age or geriatric issues).

- I have noted that an unusually high percentage of claimants have children (of any age) who are receiving psychopharmacological intervention – mental health treatment for ADD, ADHD, depression, bi-polar disorder, etc.

  - By reviewing case records, it can easily be determined if the prevalence of those three potentially contributory variables (i.e., 1) bariatric surgery; 2) a disabled parent; 3) a child receiving psychopharmacological intervention) is significantly higher among Workers Compensation psychiatric claimants than within society as a whole.

  - It can be determined if any of those contributory variables are correlated with duration of disability in the identified claimant (in comparison to a cohort of claimants whose histories are free of those issues)

  - It can be determined if any of those contributory variables are correlated with the number of psychotropic medications the claimant has been prescribed to the time of the evaluation (again compared to a cohort with negative histories)

- If any of those correlations are positive, then it can be postulated that it may be cost-effective to take into consideration the corresponding variable (as well as other currently “unknown” variables) in developing a comprehensive and cost-effective mental health treatment plan; i.e., current EBM criteria are incomplete.

  - If that can be established, the next step would be to formulate a way to take into account the complexity, non-linearity, and uncertainty that is inherent to mental health treatment issues in order to develop a more accurate (and appropriately flexible) set of treatment guidelines.

  - *If there are positive findings, both psychodynamic and biophysiological explanations may be explored. For example:*

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- *Patients status post bariatric surgery may be more vulnerable to affective dysfunction due to disorders related to micro-absorption of nutrients; and/or they might be vulnerable to do changes in body image, identity and interpersonal relationships that are the result of significant weight loss.*

- *Patients with disabled parents may be more vulnerable due to stress and worry about the parent; unconscious identification with the parent; and/or a biological predilection to certain types of injuries.*

- *Patients with children receiving mental health treatment may be more susceptible to injury due to stress, guilt, anger etc. due to their personal situation; or the illnesses in the children may reflect a constitutional/hereditary vulnerability.*