Intensive Community-Based Treatment for Complex Psychiatric Problems

MindWork Group

SILVER HILL NEW YORK

Disclosures

Thomas Franklin has no relevant disclosures.

Marina Nikhinson has no relevant disclosures.

Zachary Cordner has no relevant disclosures.

Matthew Griepp has indicated a relevant financial relationship with an ACCME-defined commercial interest, Tetricus Inc., Advisor. Their presentation will be evidence-based and unbiased. All relevant financial relationships listed have been mitigated.

Lindsay Dow has indicated a relevant financial relationship with an ACCME-defined commercial interest, Tetricus Inc., CEO. Their presentation will be evidence-based and unbiased. All relevant financial relationships listed have been mitigated.

Objectives

1. Discuss approaches for leveraging psychoeducation and continuous assessment in evidence-based psychiatric treatment,

2. Describe methods for developing a learning system for improving intensive outpatient treatment,

3. Define methods for integrating data collection and return of results into high intensity treatment modalities.

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Director of Research

MindWork Group

Intensive Treatment
Community Setting

Premise

Observations:

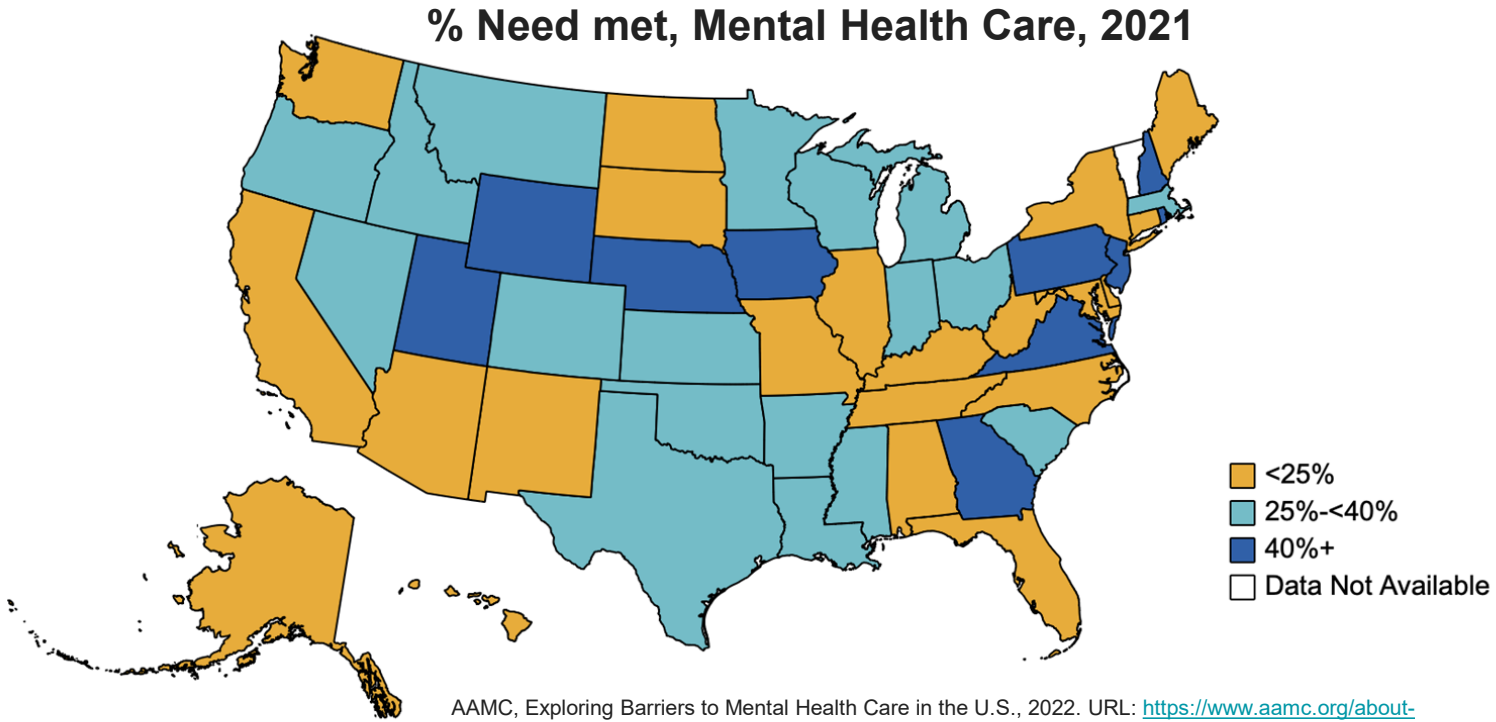
1. The ends of the psychiatric continuum of care are fraying.

2. Delivery of psychiatric services is often dis-integrated, and innovation often occurs in siloes removed from the community context.

Thesis:

Opportunities exist in the continuum's middle ground to deliver excellent, integrated psychiatric care in a community setting, which can be a driver for nimble innovation.

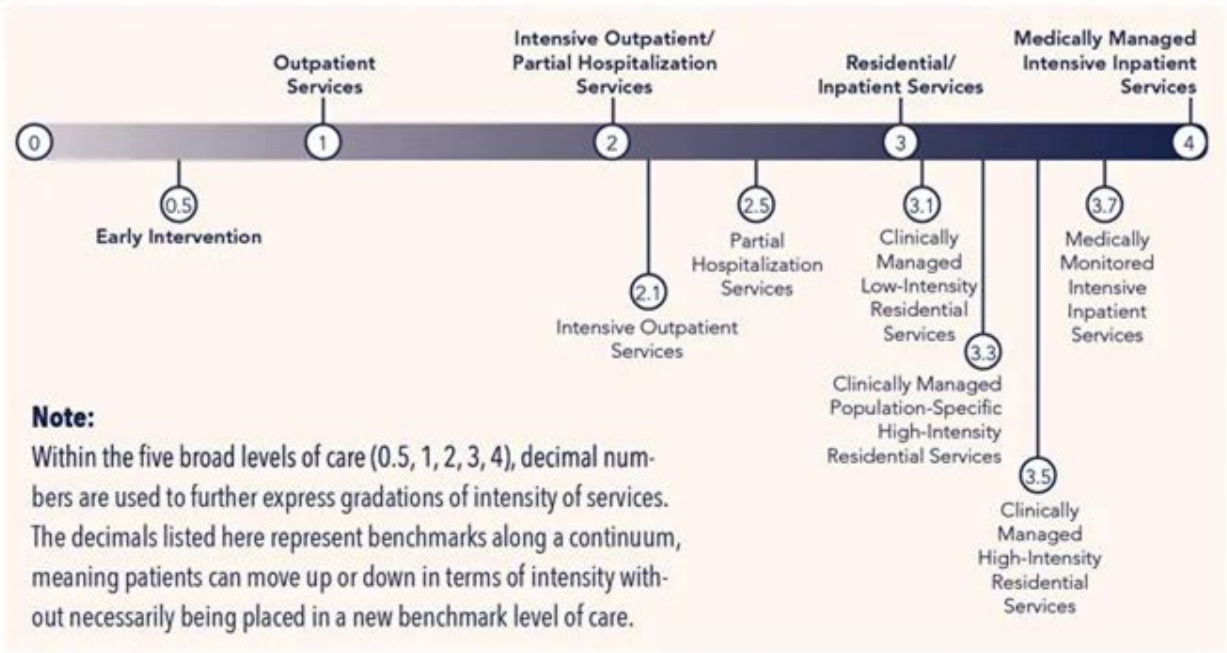
Background



AAMC, Exploring Barriers to Mental Health Care in the U.S., 2022. URL: https://www.aamc.org/about-us/mission-areas/health-care/exploring-barriers-mental-health-care-us#:~:text=No%20Insurance%20Accepted,similar%20for%20Medicare%20and%20Medicaid.

Background

Continuum of Psychiatric Care



From American Society of Addiction Medicine. URL: https://www.asam.org/asam-criteria/about-the-asam-criteria

Background

Recommended bed capacity per 100,000 residents

Optimal	Minimal
60	30

Mundt AP, Rozas Serri E, Irarrázaval M, O'Reilly R, Allison S, Bastiampillai T, Musisi S, Kagee A, Golenkov A, El-Khoury J, Park SC. Minimum and optimal numbers of psychiatric beds: expert consensus using a Delphi process. Molecular Psychiatry. 2022 Apr;27(4):1873-9.

Maryland, inpatient psychiatric beds per 100,000 residents

2010	2018	2020
36	34.6	21.3

Maryland Health Care Commission, State Health Plan for Facilities and Services: Acute Psychiatric Services, 2021. URL: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/psychiatric_services/con_comar_10_24_21_20210809.pdf

Maryland Health Care Commission. URL: https://mhcc.maryland.gov/mhcc/pages/apcd/apcd/apcd.aspx

Background

Inpatient LOS at a single academic medical center

2005[1]	2017[2]	2019[3]
23.8	9	7.4

Short LOS-associated outcomes

-Lower global functioning, lower work functioning [1]
-Greater depressive symptoms [1]
-Increased readmission risk [2]
-LOS <7 days associated with increased suidice risk [2]
-LOS <14 days associated with increased suicide risk [2]

[1] Megna, J.L., Aneja, A., Sauro, M., Ahmad, N., Simionescu, M., Mustata, G., Rojas, M.H. and Wade, M., 2015. Awareness of treatment needs and length of stay amongst psychiatric inpatients. *Comprehensive psychiatry*, *63*, pp.65-70.

[2] Leontieva, L., Golovko, S., Adhlakha, A., Polinkovsky, L. and Harris, C., 2017. Attention, concentration and planning ability improvement in response to depression treatment during acute psychiatric hospitalization. *Clinical Depression*, *3*(02), pp.2572-0791.

[3] Shah, B., Leontieva, L. and Megna, J.L., 2020. Shifting trends in admission patterns of an acute inpatient psychiatric unit in the state of New York. *Cureus*, *12*(7).

[1] Lieberman, P.B., Wiitala, S.A., Elliott, B., McCormick, S. and Goyette, S.B., 1998. Decreasing length of stay: are there effects on outcomes of psychiatric hospitalization?. *American Journal of Psychiatry*, *155*(7), pp.905-909.

[2] Oh, H., Lee, J., Kim, S., Rufino, K.A., Fonagy, P., Oldham, J.M., Schanzer, B. and Patriquin, M.A., 2020. Time in treatment: Examining mental illness trajectories across inpatient psychiatric treatment. *Journal of psychiatric research*, *130*, pp.22-30.

Background

Abundant evidence has identified strain on outpatient psychiatric care, with evidence of increasing fragility.

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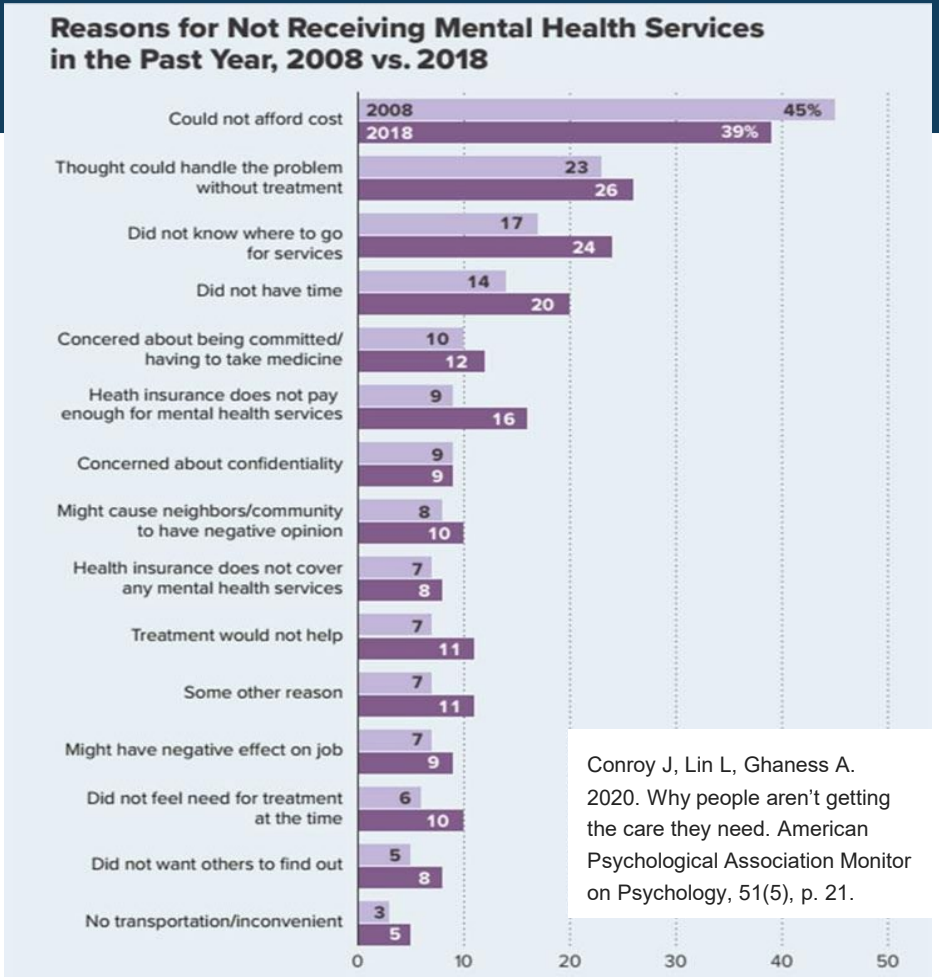
Gao, Y.N. and Olfson, M., 2025. High out-of-pocket cost burden of mental health care for adult outpatients in the United States. *Psychiatric Services*, *76*(2), pp.200-203.

Haizelden, J., Kim, N. and Payne, M., 2025. Factors Associated with Mental Health Service Utilization, Perceived Unmet Need, and Barriers to Treatment Among US Adults with Disabilities. *American Journal of Health Education*, pp.1-13.

Schneeberger, A.R. and Huber, C.G., 2022. Crisis within a crisis–the fragility of acute psychiatric care delivery. *World Psychiatry*, *21*(2), p.245.

Mongelli, F., Georgakopoulos, P. and Pato, M.T., 2020. Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus*, *18*(1), pp.16-24.



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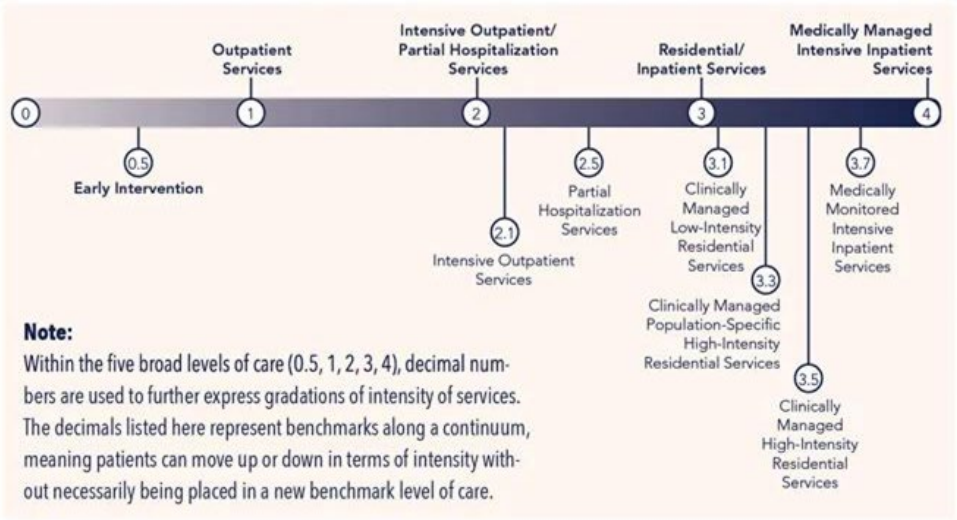
Background

Continuum of Psychiatric Care



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Unique benefits and opportunities of intermediate-level care are well established

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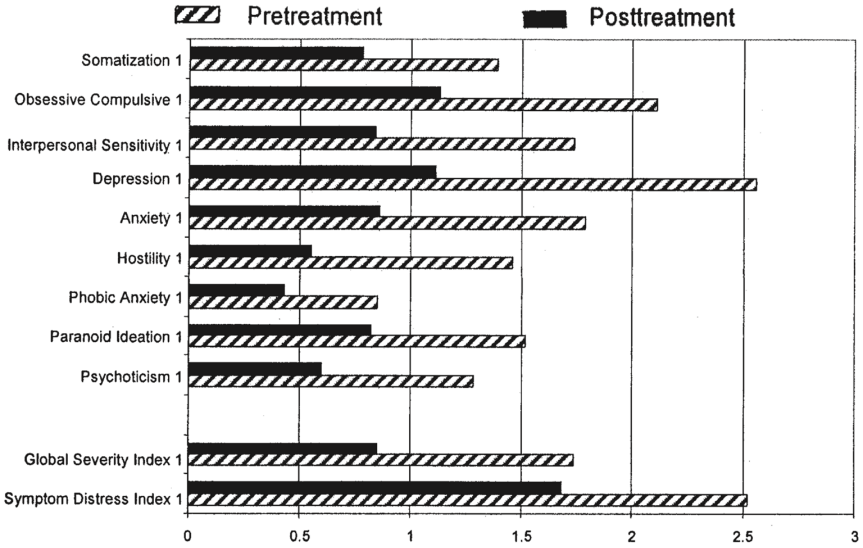
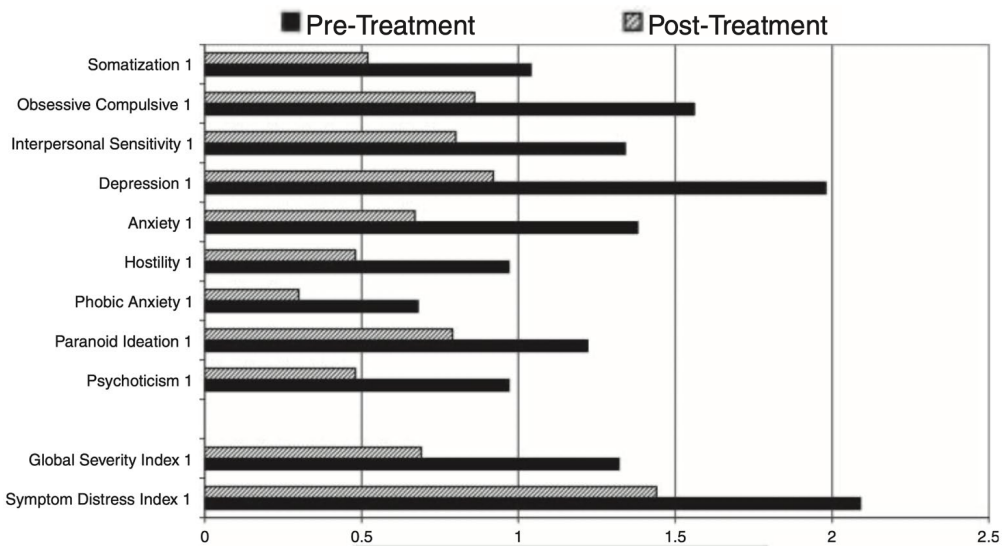
Background

Effectiveness of a private-practice IOP



Wise EA. Effectiveness of Intensive Outpatient Programming in Private Practice: Integrating Practice, Outcomes, and Business. American Psychologist. 2005 Nov;60(8):885.

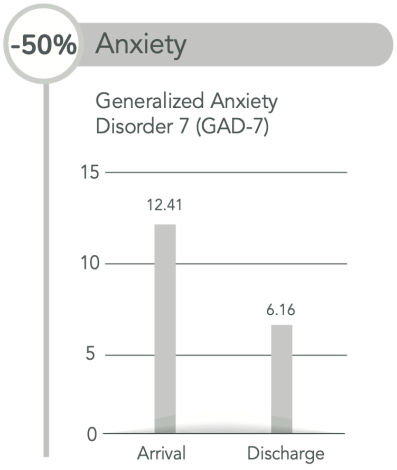
Effectiveness of a private-practice IOP among dual diagnosis patients

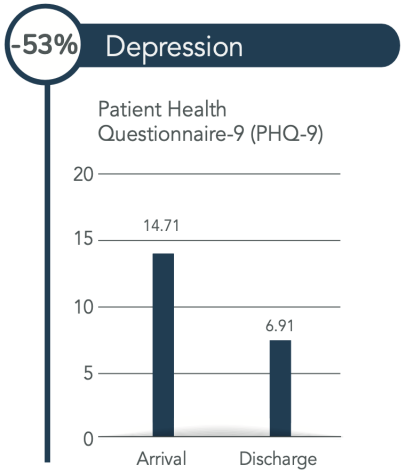


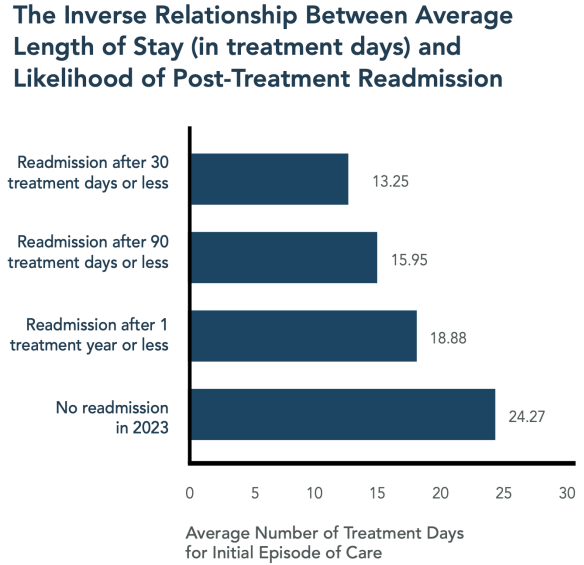
Wise EA. Evidence-based effectiveness of a private practice intensive outpatient program with dual diagnosis patients. Journal of Dual Diagnosis. 2010 Feb 10;6(1):25-45.

Background

Effectiveness of a private-practice IOP







Comprehensive Model

Comprehensive Assessments	Group Therapy	Individual Therapy	Family Therapy	Psychiatry	Experiential & Educational

Welke C, Schreiber D, Serio J, Muller P, Hope B, Jones K. Advancing Mental Health Care: The Critical Role and Effectiveness of PHP and IOP Programs [white paper]. 2024. URL: https://app-na1.hubspotdocuments.com/documents/21203846/view/1048371079?accessId=edb104

A feasible model of community-based treatment

Aim 1: To develop a feasible, longitudinal intensive treatment program integrated into an outpatient multidisciplinary practice.

Aim 2: To create a learning system driving improvement of the model on a programmatic and individual patient basis.

Aim 3: To robustly study the model in collaboration with like-minded programs and establish best practices.

Overview - MindWork Intensive Outpatient Program

- Milieu of a maximum of 9 patients
- Multidisciplinary team of experts, led by 3 psychiatrists
- Approx **20 treatment hours** weekly
  - **15 hours of group therapy** weekly, Monday-Friday
  - **5-7 hours of individual sessions** weekly, Monday-Friday
- Minimum commitment of 2 weeks, **Average length of stay: 4-5 months**
- Individual treatment
  - 3x/week individual therapy and psychiatric assessment
  - family therapy, art therapy, occupational therapy, recreational therapy
- Supportive Housing offered in conjunction with the IOP
- Transcranial Magnetic Stimulation offered in conjunction with IOP

Foundational Principles: Education

- Mentalization, Attachment Theory, Internal Family Systems theory
- Psychodynamic principles
  - Paranoid Schizoid/Depressive positions, Dyadic and Triadic relationships, Transference Experience, Compromise Formations
- Understanding one's own and others' minds - find the lens that works
- Staying in touch with reality for growth and development
- Areas where psychosocial development was disrupted
- Sophisticated education about neuropsychiatric aspects of mental illness
- Psychiatric management - clarifying diagnoses, deprescribing, sensible pharmacology, advanced TMS

Foundational Principles: Community

- **Therapeutic community** - what does it take to be a member of a community?
- **Therapeutic intimacy** - knowing each other in deep and useful ways to foster a sense of purpose, trust and accountability in relationships
- Individual and family therapy enhanced through **understanding relationships in the program**
- **Attuned clinical self disclosure** - Ubiquity of non mentalizing experience, common pitfalls and vulnerabilities of being with others, transference interpretations among the patient group and with staff
- **Normalizing activities** to decrease isolation and increase connection - community potlucks, therapeutic outings, patient led activities at Kairos House
- **Clinical team as a community within the larger treatment community**

Foundational Principles: Practice

- **Gradual Transitions**
  - Return to work, school, volunteering, and family responsibilities - identifying key struggles and barriers in real time

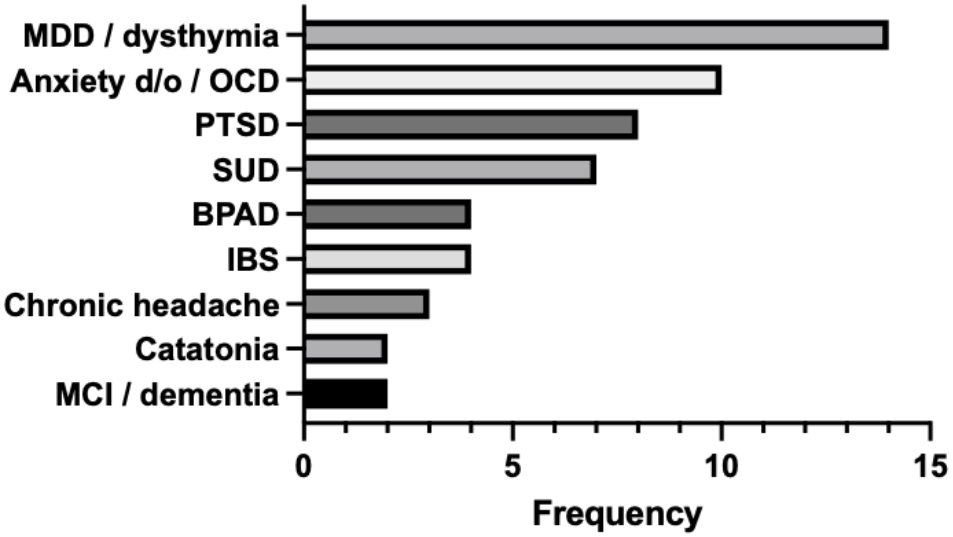
- **Occupational therapy, recreational therapy, and individual therapy**
  - development and strengthening of emotional regulation, resilience and capacity for sustaining effort

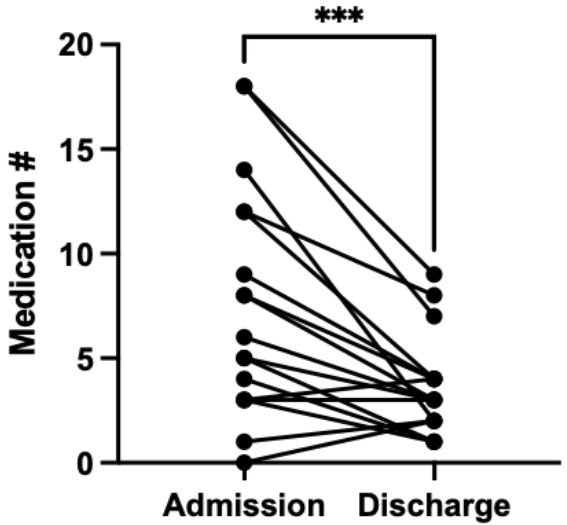
- **Family therapy work**
  - changing dysfunctional communication and relating patterns, working through acceptance and grief

- **The team and community walk side by side** with each patient through their successes and failures
  - celebrating wins, recognizing poor decision making, opportunities for growth, pivoting and recognizing old patterns

OUTCOMES

Containing Complexity





Measurement informed care - A representative case

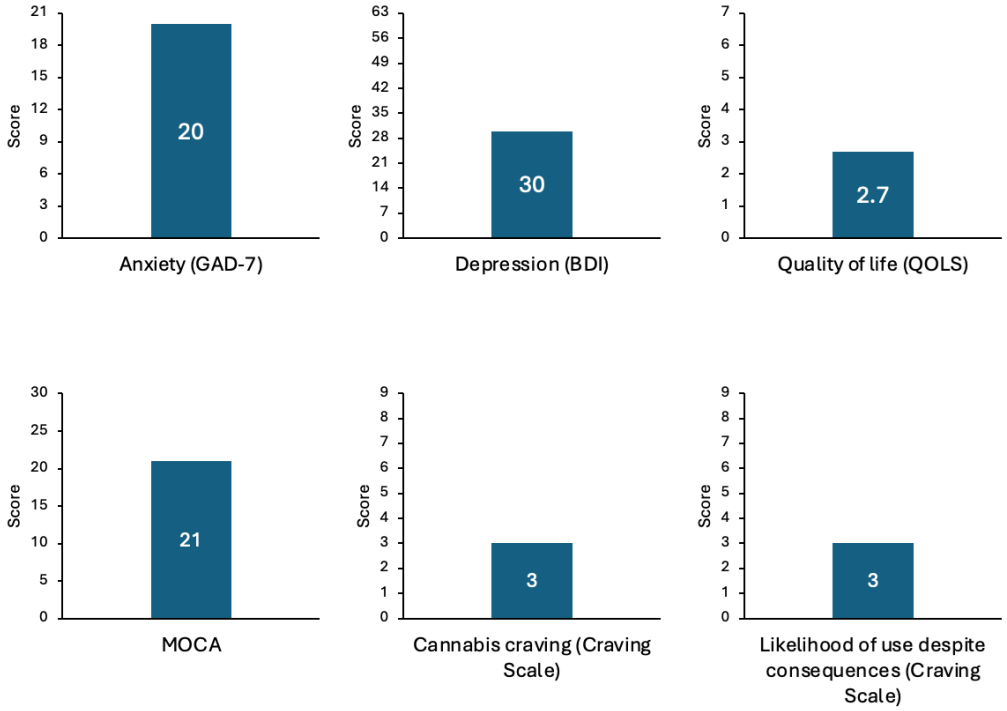
-Middle-aged pastor with a history of OCD and MDD.

-Early 2025, developed worsening anxiety and difficulty falling asleep in the context of work stressors.

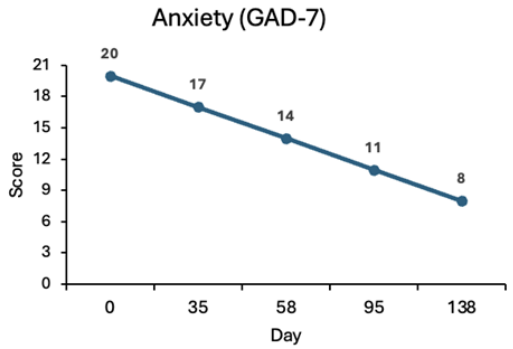
-Abandoned 1st line treatments after being prescribed cannabis, with rapidly escalating use.

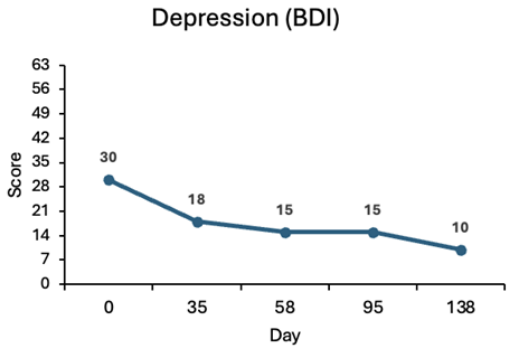
-Then prescribed steroids for an inflammatory skin condition, with worsening insomnia, anxiety, and recurrence of depression.

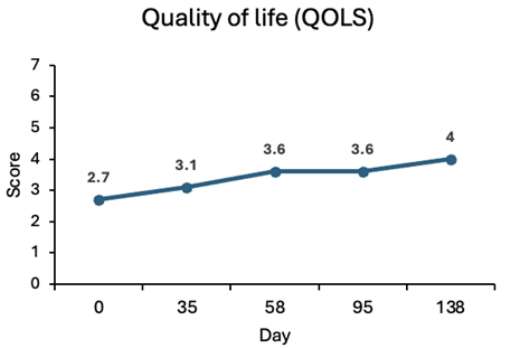
-Prescribed 3 additional cannabis products with onset of psychotic symptoms and cognitive impairment, ultimately resulting in referral for IOP-level treatment.

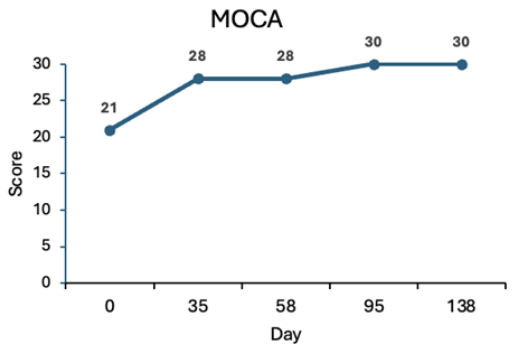


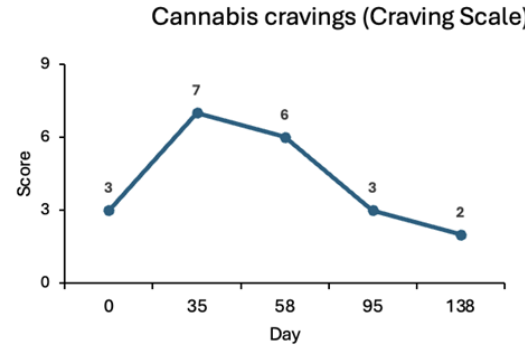
Measurement informed care - A representative case

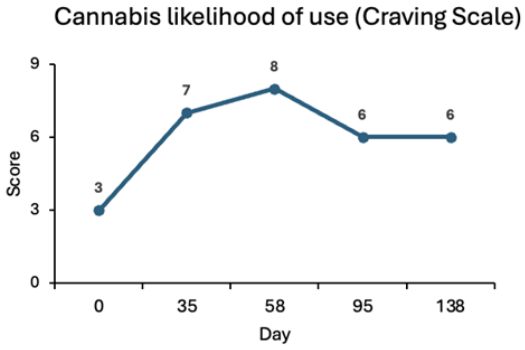




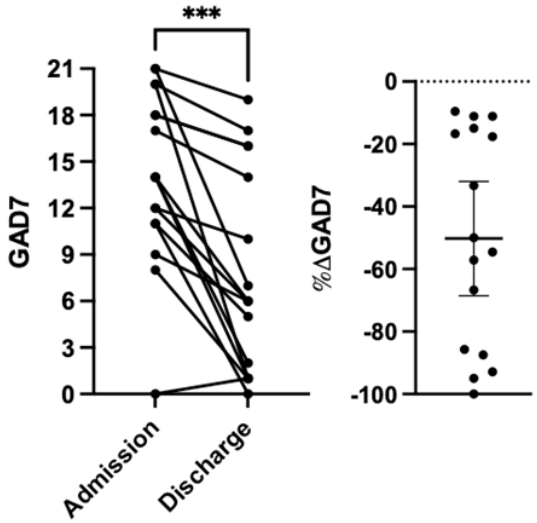


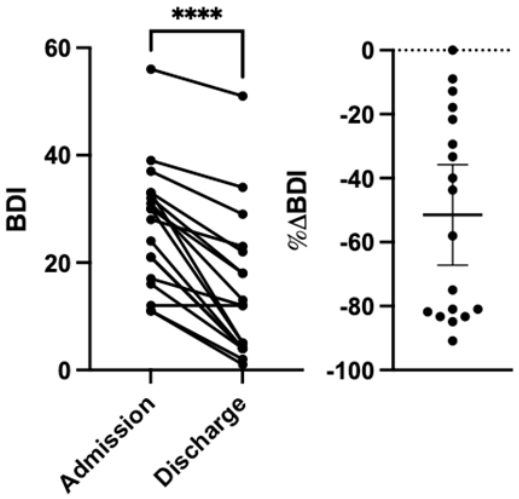


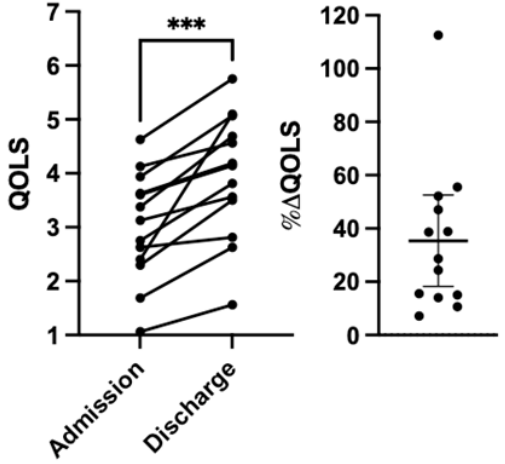




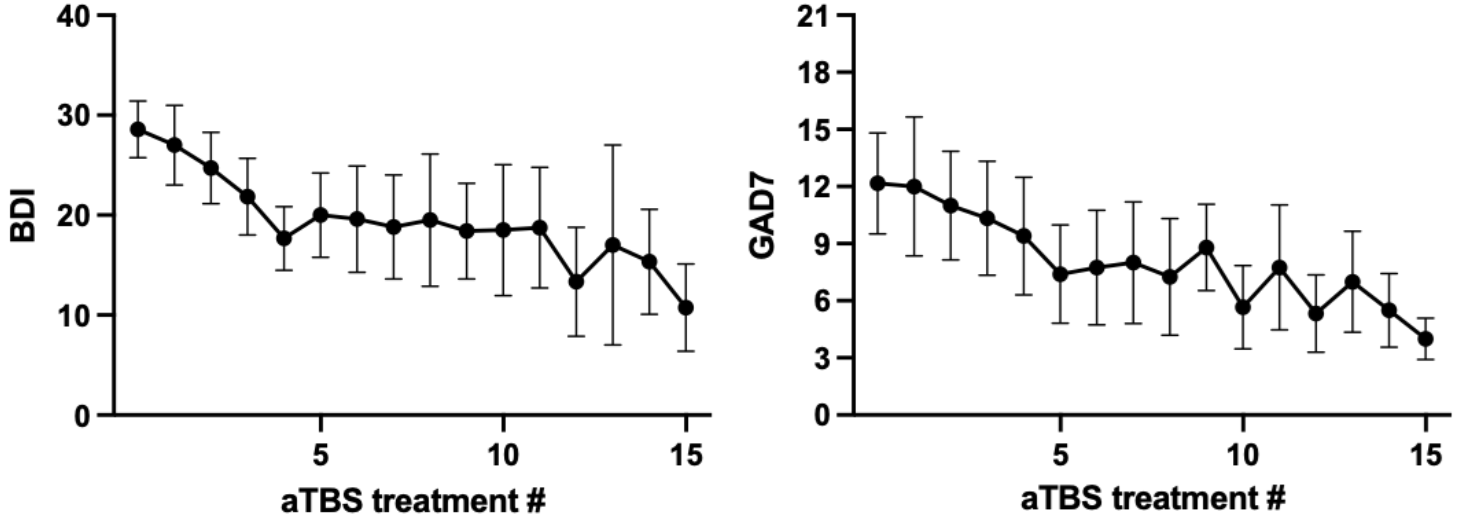
Outcomes at discharge







Innovation



aTBS protocol adapted from: Ramos MR et al. Accelerated theta-burst stimulation for treatment-resistant depression: A randomized clinical trial. JAMA psychiatry. 2025 May 1;82(5):442-50.

Final Thoughts

- Intensive treatment for complex patients in a community-based private practice setting is feasible

- The model successfully integrates
  - Intimate, multidisciplinary treatment
  - Coordination of care for severe and complex cases
  - A measurement-informed approach
  - Nimble innovation within a learning health system

- Study, validation, and outcome-informed improvement of this model are areas of ongoing pursuits

Silver Hill New York's Mental Health Intensive

Building a data-informed personality disorder treatment program

Dr. Matthew Griepp, MD
Psychiatrist in Charge, Mental Health
Silver Hill New York

Lindsay Dow, MBA, CPS-P
Program Director, Silver Hill New York
Founder & CEO, Tetricus Labs

Agenda

Designing SHNY
Thinking about data in psychiatry
Centralizing the treatment review
Lessons learned & next steps

Silver Hill New York

Substance Use

Mental Health Intensive

Intensive Outpatient Program
- 8–12-week intensive outpatient program
- Monday, Tuesday, Thursday 9a-12p
- MBT, DBT, Art Therapy, Process

Evening Intensive
- 2-week intensive program
- Monday-Friday 5:30p-7:30p
- Psychoeducation + Assessment

Daytime Intensive
- 8+ week intensive program
- Monday, Tuesday, Thursday 12p-3p
- MBT, DBT, Psychoeducation, Assessment

Building a data-native, integrated approach to personality disorder treatment

Building a richer understanding through multiple types of information

All sessions are **recorded** for assessment, supervision and quality purposes

All clients are asked to download the **app** for survey & mood collection & Apple Health sync

All clients are given an **Apple Watch** to assess sleep, activity & heartrate

All clients provide a release for **discussions with key family members** & external providers

Combining elements from different approaches

Andrew J Gerber, MD, PhD

President & Medical Director,
Silver Hill Hospital

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Anthony Bateman

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Co-Founder, Mentalization Based Therapy

Thinking about data in psychiatry

Two diverging paths?

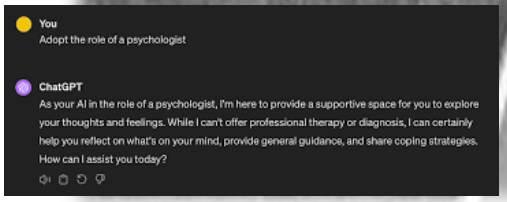
Technology

I can do it on my own!

An increasing number of patients are turning to ChatGPT with their problems – leveraging LLMs to understand "what's going on here" and "what should I do about it?"

Many are also seeking to explain their difficulties in ways that can be measured exclusively by wearables: "turns out problem was my sleep. If I just fix my sleep, I'll fix my problems."

Both assessment and treatment are being coopted by a process both desperate for answers while rejecting of expertise.



Psychiatry

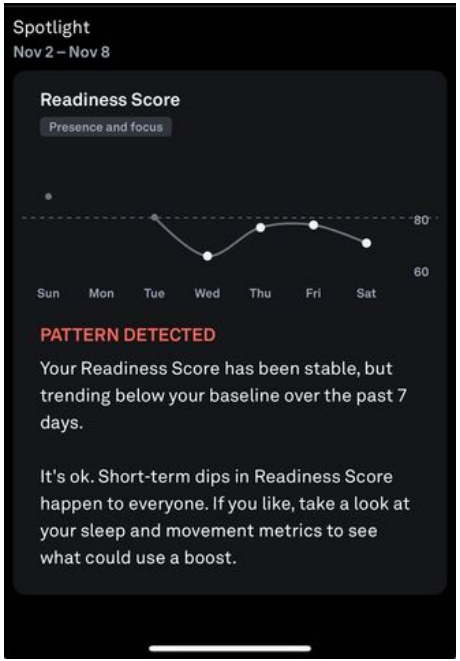
I must fully turn myself over to experts!

On the flip side, psychiatry historically has demanded that patients trust blindly in expertise – positing that patients will "get better" if they follow the treatment protocol, but without a nuanced, clear conception of what "better" means or any way to track progress meaningfully over time.

The problematic aspects of the technology-alone approach

- Eliminates the working relationship and our expertise and experience from the equation
  - Loses the process of two minds working together on one mind
- Algorithms are designed problematically
  - LLMs are designed to minimize prediction error rather than generate change
  - Reinforces rather than challenges self conception and defenses, by design, potentially fragilizing the client
  - Corporate pull to optimize for engagement and utilization rather than accuracy and reality
- Simple attribution of complex problems
  - e.g. if I just sleep more or am not on my period…

Data & technology as therapist/treatment raises a host of challenges, particularly for those with Personality Disorders



Serves the unproductive function of circumventing conflicts around trust and dependency

- Reinforces a sense of omnipotence, the possibility of self optimization and self preoccupation (i.e. a narcissistic defensive structure)
- The data becomes the authority leading the patient. This may feel like a potentially less dangerous form of dependency/subjugation for those struggling with epistemic trust. After all, the data is from you (plus an algo) and doesn't require relying on the mind of another human with all of its potential dangerousness, inadequacy, unclear agendas, etc

Builds a reductive and overly teleological framework for self-understanding

- Patients are often seeking to be organized from the outside in – which can be facilitated by the oversimplified readouts and overdrawn extrapolations that technology readily provides (see figure)
- They are also often trying to structure their worlds with themselves teleologically (e.g. what's my optimal working schedule based on "stress" score)

…but technology also enables us to collect and manipulate data in new and exciting ways

- Reality Backstop: It gives us the opportunity to potentially bring in objective representations of intersession happenings in the lives of our patients that had always been reported subjectively
- Clinical Signs: It potentially adds new data-driven in and inter-session signs into the clinical conversation that were hitherto unavailable
- We can learn individualized relationships between the patient and data to better understand each individual patient's story
- Data as Rorschach: how patients engage with all facets of this system are interpretable and useful
- There's a wider array of data around a patient that is common and un-interpolated in its transmission both within clinical teams as well as with the patient across encounters
- Technology in general can enable us to record, store and process much more data than any single human mind, albeit with new and different biases than human observers
- Has the potential to learn about the efficacy of approaches across patients, to improve patient care over time

Core values to ground this endeavor

Patient-Centered

Data should only be used by clinicians in transparent partnership with patients and with the purpose of empowerment.

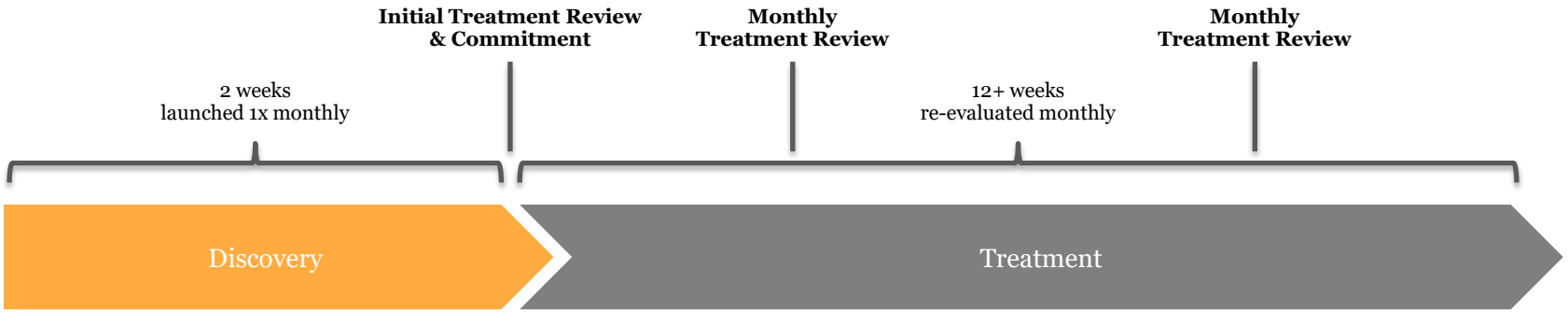
Depth-Oriented

Data should be used as part of a holistic and deep modeling of the patient's self and relationship with others, in the context of a depth-oriented treatment.

Learning System

Data should facilitate the modeling of curiosity, "not knowing" and iterative learning. It should be introduced tentatively and thoughtfully and should not be used to facilitate premature certainty or overdrawn conclusions.

Program structure



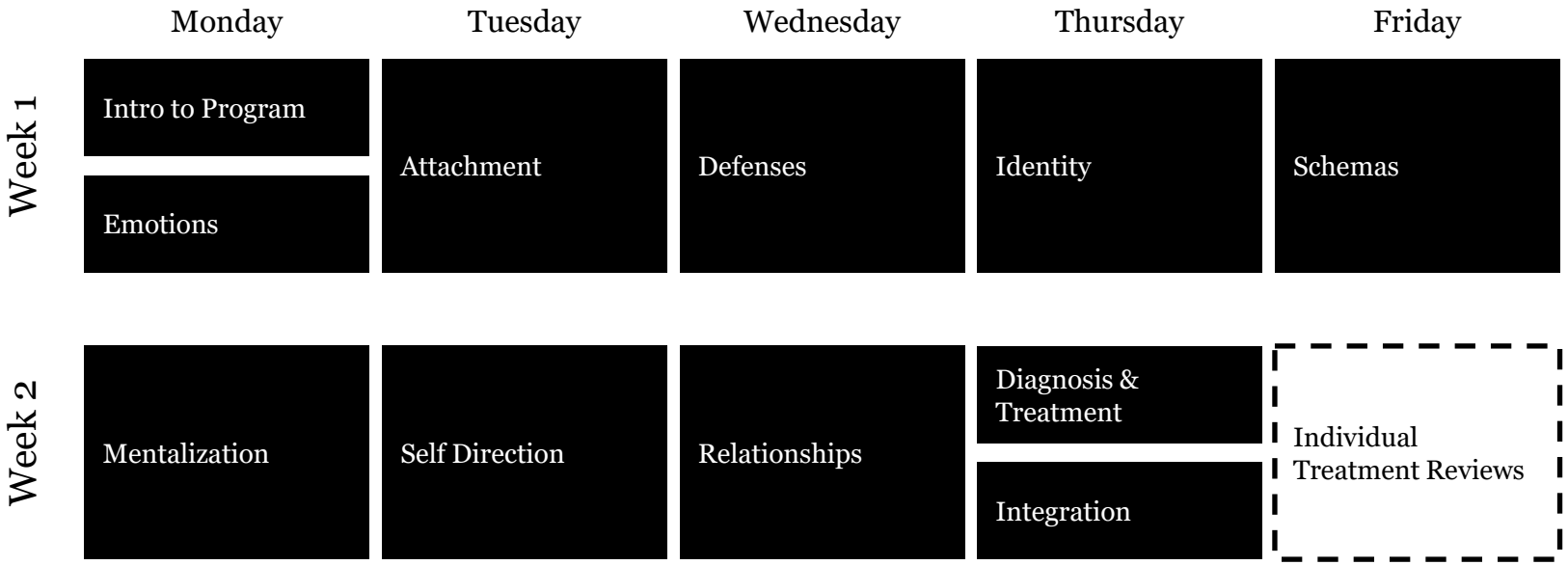
- In-Depth Assessment
- Psychoeducation

- Individual med management & therapy
- Daytime & evening groups
- Family engagement & programming
- Care coordination with external recommended services

- Personalized Formulation & Treatment Plan

Psycho-education Schedule

Pull the back curtain and arm clients to be co-constructers of their own conceptualization, mechanism of change, progress indicators and goals



Centralizing the Treatment Review

Philosophy of the formulation letter

Immediate Goal:

- A first attempt at a formulation of the patient's difficulties, which integrates our understanding of the patient's subjective experience, objective data, validated assessment measures, outside collateral and multiple clinician impressions into a coherent narrative that feels personalized, resonant, motivating and capable of being condensed down into a plan involving actionable goals (i.e. a personalized treatment plan).
- Create a personalized connection to a treatment focus, and an understanding of the type of treatment that's recommended and how/ why it should be helpful.
- Establishing a north star in the formulation that can be referenced back to as well as an agreed-upon series of measures to track progress.

Additional aspirations for this process:

- We aim to model the necessarily tentative process of weaving together what can seem like a disjointed set of experiences into the beginnings of a coherent understanding of self and challenges.
- Creating a framework for trust: Modeling the beginnings of a safe, reliable and patient-centered partnership in putting together that understanding – often in contrast to treatment and family attachment paradigms: "they truly see and want to help me!"
- An approximation of a partnered "we-mode" experience: looking together at co-constructing this narrative – using the patient's language but clearly interpolating thoughtfully and usefully through the collective minds of the clinical team, creating a sort of metabolized corrective attachment experience.

Formulation: Letter & Treatment Review

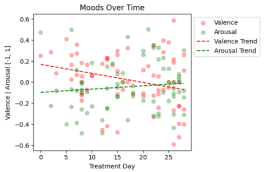
How we understand your challenges

Treatment focus & anticipated hurdles

Recommended treatment plan & progress measurements

What we've learned

Mood Patterns



Over the course of the last month, you've done an excellent job of tracking your mood regularly. Your moods in general seem to cluster around neutral, with only 2 entries over the period at an intensity level above a 5. We've seen a trend over the month of your moods becoming more negative, with your overall energy level increasing slightly over time.

General Observations:

- Sleep is paramount: Good sleep consistently triggers positive moods (Alert, Content, Relaxed), while poor sleep is a dominant trigger for negative moods (Depressed, Distressed, Tired).

[redacted]

Specific Emotional Triggers:

- Depressed, Sad, or Distressed
  - Poor sleep or tiredness: This is a very frequent and strong trigger, leading to feelings like "can't sleep," "so tired," "bad lazy day," or feeling "under the weather" and "insecure."

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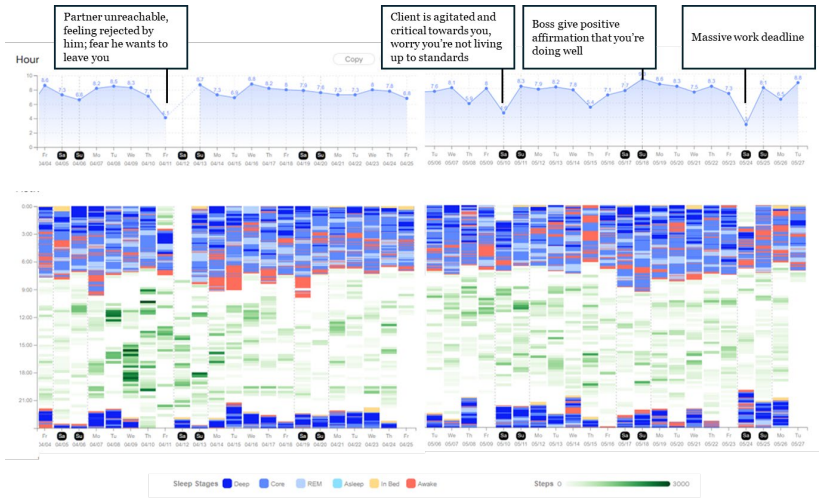

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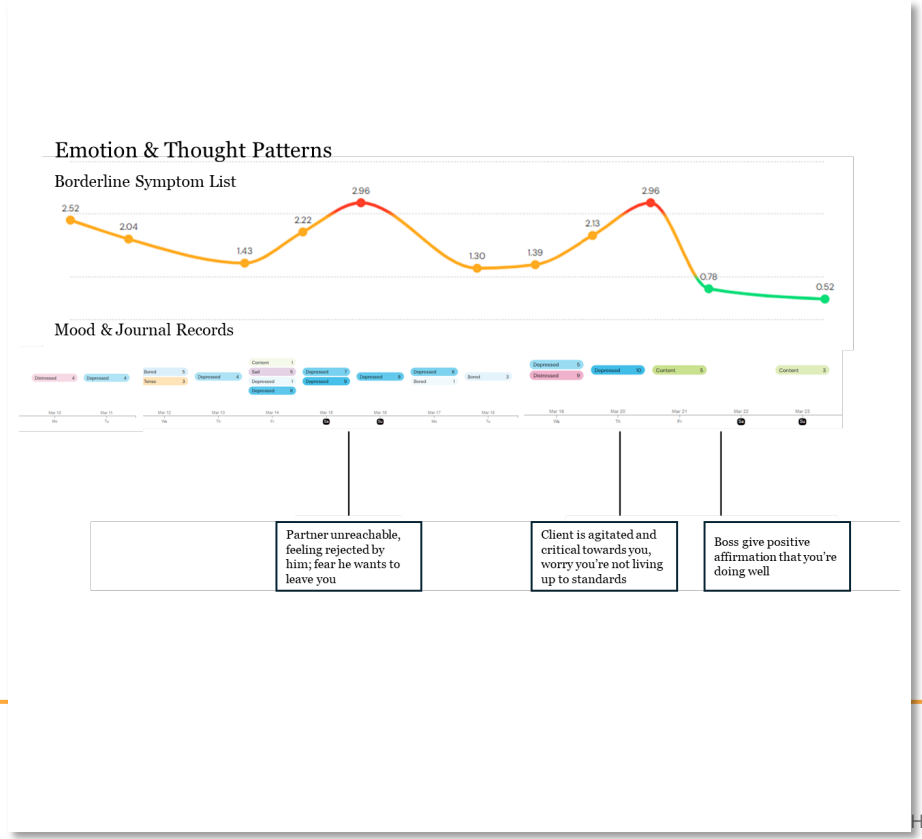

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Personality Function

Levels of Personality Function

Identity (Z = +2.05 SD above the norm)

Your responses suggest a high level of impairment in identity functioning. You may experience significant instability in how you perceive yourself, with self-worth and self-definition shifting depending on context or external feedback. This degree of elevation suggests a fragmented or fragile sense of self, leading to inner conflict, self-doubt, and difficulty sustaining a coherent identity over time.

Self-Direction (Z = +2.60 SD above the norm)

You report severe impairment in self-direction. This indicates profound challenges in establishing and pursuing meaningful long-term goals, along with uncertainty about which values should guide your decisions. Goals may shift inconsistently, or be heavily influenced by external expectations, leaving you without a stable or authentic framework for direction. This represents one of the most pronounced difficulties in your profile.

Empathy (Z = +1.19 SD above the norm)

Your empathy score reflects moderate impairment. While you are capable of perspective-taking and attunement at times, there may be inconsistency in your ability to accurately perceive and respond to others' experiences. These fluctuations can create challenges in emotionally charged or nuanced interactions.

Intimacy (Z = +0.30 SD above the norm)

Your responses suggest mild difficulty with intimacy. You are able to engage in relationships and sustain them, but you may at times struggle with closeness or vulnerability. These difficulties appear modest compared to other domains, and do not prevent you from forming meaningful connections, though they may limit their depth.

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How we understand your challenges

The difficulties you're currently facing seem to originate from a combination of your innate interpersonal hypersensitivity and your unique experiences as a child. You describe growing up as the extension of two parents – while they were successful, wealthy, and placed on a pedestal, you also describe them using you as a way to bolster how they saw themselves. You were kept separate from normal life, forbidden from making friends and physically isolated from others. Under these conditions, you became skilled at understanding what your parents and others wanted and became what they wanted to secure your parents' approval. While this strategy proved highly effective both then and – under some circumstances still today – it left a deep emptiness where your core identity should have been. We wonder if this emptiness, and not really knowing what you want for yourself, might be understood as a way to protect yourself from the even scarier thought of wanting something different from what your parents wanted, which, you seemed to feel, would have put the whole relationship in danger.

Perhaps to survive feelings of profound loneliness -- now accompanied by what you describe as a "claustrophobic" sense of being invaded and like your own self was being erased, you have developed a few coping strategies. First, you seek to find joy in completely giving in to what other people need, picturing yourself emotionally gratifying and rescuing your parents by giving up your own body, mind, and soul, which would allow you to avoid their anger, rejection, and abandonment and give you some control over your connection with them. On the flip side, you also describe surreptitiously rebelling against that feeling of being erased by doing things like eating too much, watching too much TV, and, more recently, attacking the things that matter to you when they feel like they're going to take away your freedom – like school, work, or serious relationships. Finally, you describe extreme indulgence in a world of grandiose fantasies of omnipotent control and benevolent domination through unspecified "greatness" in your career.

We meet you now just after your mother has been diagnosed with a terminal illness. In some ways it feels that the person on whom you'd built your identity is rapidly disappearing and a deep emptiness remains. We suspect this profound loss has triggered the significant increase in your anxiety and suicidality – a feeling that without her, there may not be much left to you and to life itself. You've come to treatment to find a way forward – to build a sense of self and life that's all your own, and that's what we're here to help you do.

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Treatment Focus

- Facilitating the development of an authentic sense of self and personal desires
- Exploring and modifying long-standing patterns of interpersonal hypersensitivity and people-pleasing: Unpacking your skill at understanding what others want to secure approval, and the coping strategy of completely giving in to what other people need, to establish healthier boundaries and self-assertion.
- Processing the profound impact of your mother's terminal illness and associated grief and addressing the deep emptiness that's triggered.

Anticipated Hurdles

- Resistance to developing an independent self due to fear of relational rupture: The client's deeply ingrained fear that "wanting something different from what your parents wanted... would have put the whole relationship in danger" may translate into an avoidance of genuine self-discovery in therapy if it feels like a betrayal or risks the therapeutic relationship.
- Manifestation of "surreptitious rebellion" within the therapeutic context: The client's pattern of "attacking the things that matter to you when they feel like they're going to take away your freedom" (e.g., school, work, relationships) could manifest as passive non-compliance, missed sessions, or undermining progress in therapy.
- Reliance on people-pleasing or grandiose fantasies to avoid confronting difficult emotional work: The client may find it challenging to express genuine disagreement or needs in therapy due to "interpersonal hypersensitivity" and people-pleasing, or retreat into "grandiose fantasies of omnipotent control" as a defense against vulnerability or the perceived "claustrophobic" nature of self-exploration.

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Treatment Recommendations

Assessment
- Mental Health Intensive – discovery phase (complete)

Medications
- Abilify, 5mg – for improved mentalization / interpersonal distress tolerance
- Propranolol, 10mg, PRN – for anxiety

Therapy
- Medication Management – Matthew Griepp, MD, biweekly
- Individual Psychotherapy – Brigid Meagher, LMHC, weekly
- MBT Group – weekly
- DBT Group – weekly

Key Measures

- Sleep (duration, onset, wake time) – rule out bipolar I & II, track manic defenses
- Time at Home – work on opposite action to withdrawal to spend more time out of the house
- Borderline Symptom List – to track levels of distress
- Medication Tracking – to understand how meds are impacting distress
- Mood Journal

This focus then translates into a relational passport for MBT, as well as goal-setting for DBT

Relational Passport

Past
- Innate interpersonal hypersensitivity
- Narcissistic extension of parents
- Isolation from peers, others; trained to feel apart / superior

Present Trigger #1
Others are dissatisfied by you and feel at risk of disconnecting

View of Self in these moments
- Profoundly alone, abandoned, helpless
- Confused, empty
- Angry, self-righteously punishing

View of Others in these moments
- Abandoning, rejecting
- Attacking, unrealistic
- Uncontrollable

Emotions when triggered
- Panic
- Anger / Rage

Coping Mechanisms & Defenses:
- Histrionic panic, crying, help-seeking
- Sadistic control & punishment
- Manic defenses: overwork, limited sleep
- Withdrawal through TV, binge eating
- Substitution – finding another person to latch onto

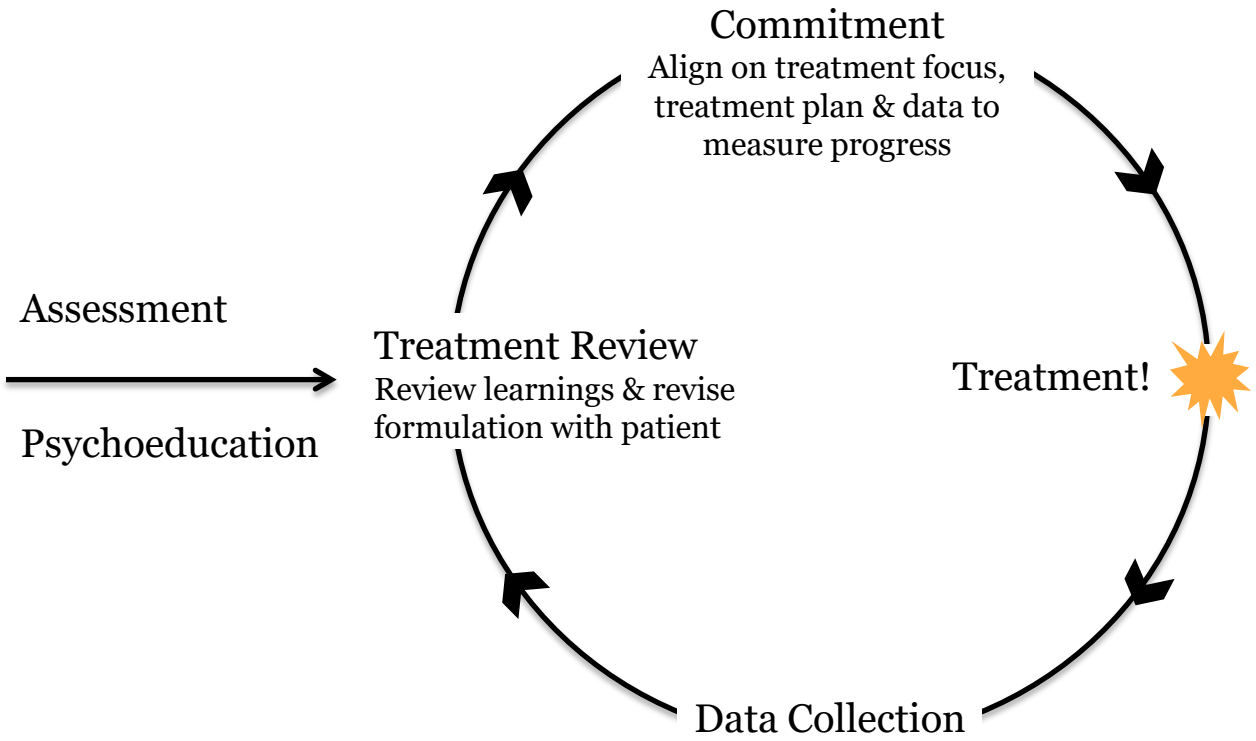
Mentalizing Challenges
- Teleological mode
- Psychic equivalence
- Other focus

Key Schemas
- Unrelenting standards
- Subjugation
- Social isolation

Goals of Treatment
- Build tolerance for the vulnerability of needing others, even when you don't get those needs met
- Hold good and bad views of self simultaneously to build more robustness to criticism and perceived rejection

Anticipated Hurdles to Treatment
Feeling like other's problems are not relevant to you
Dismissing the treatment: feeling like the treatment isn't good enough

Closing the loop:
personalized treatment focus & plan underpinned by data



Continuing to model the process of integrating a complex array of information from patient subjective experience, objective data, and clinician impressions in partnered process that can then be condensed into a shared set of actionable goals and treatment modifications.

Key Learnings & Next Steps

Some preliminary observations from using the data

Challenging our preliminary hypotheses:

- While we suspected data might engender paranoia / suspicion, in many patients it engenders trust
- Instead of engendering rigidity, it can enhance curiosity in both patient and clinician

Invites another channel of clinical communication (through content, behavior and countertransference) which emerges as a potentially useful clinical sign in itself. The different ways patients resist / embrace participation with data tells us about defenses and helps us learn about the patient.

- People pleasers
- Pan positives
- Hiding
- Communication about distress / risk
- Oppositionality / defensiveness
- Teleological: “Only select positive because I don’t want to feel negative feelings”
- Transitional object
- Aggression and devaluation through the app that they otherwise wouldn’t share
- May stoke a paranoia that patients have about the mind of clinicians: it’s a triad with patient + data against clinician
- Can also create particular challenges for those with narcissistic defenses
    - Confronts the individual with their biological limitations and constraints
    - Challenges a sense of uniqueness, by presenting the self as something reduceable
    - Generates a fear of over-susceptibility to data

Future Directions

- General protocol refinement to improve data capture and utilization
- Defining what better looks like more broadly
- Introduce session analytics as a clinical tool
- Introduce systematic goal-based outcomes measurement as a clinical protocol
- Improved treatment review outputs to make “return of results” more clinically integrated with goals of treatment

Thank you! Questions?

Connect with us!

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