THE WETC PSYCHOLOGY NEWSLETTER

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Major Depressive Disorder: Definition, Diagnosis & Treatment

A Major Depressive Disorder is a serious mood disorder that is characterized by a depressed mood and associated signs and/or symptoms. Signs are behaviors that are observed by the doctor. Symptoms, or complaints as they are sometimes called, are what the patient tells the doctor is wrong with them, which may or may not be consistent with the doctor's observations. Regardless, in order to diagnose a Major Depressive Disorder correctly the signs and/or symptoms of the disorder must be shown to have been present during the same two-week period and to represent a change from a previous level of functioning. Additionally, at least one of the signs and/or symptoms must be either a depressed mood or anhedonia, which is a loss of interest in pleasure. Major Depressive Disorders, as the name implies, are major disorders that most frequently require an individual be given significant antidepressant medication, psychotherapy, hospitalization and possibly electroconvulsive therapy.

Major Depressive Disorders fall into two main categories: Recurrent or Single Episode. Recurrent Major Depressive Disorders are diagnosed correctly when the individual has had two or more Major Depressive Episodes. Single Episode Major Depressive Disorders are diagnosed correctly when the individual has had only one Major Depressive Episode.

<u>According to the DSM-IV-TR, in order to diagnose a Major Depressive Disorder correctly, the individual must present with at least five of nine signs and/or symptoms</u>. In addition, as mentioned above, they <u>must</u> present with A and/or B on the list below, that is, either a depressed mood, a loss of interest in pleasure, or both.

In presenting a complete and credible diagnosis the doctor must identify the severity of the disorder. If the individual presents with five or six depressive signs and/or symptoms, the specifier "Mild" is used in diagnosing this condition. If the individual presents with "most of" the nine signs and/or symptoms and "clear-cut observable disability (e.g., inability to work or care for children)," the appropriate diagnostic specifier is "Severe Without Psychotic Features." Similarly, if the individual presents with "most of" the nine signs and/or symptoms and "clear-cut observable disability," and there are psychotic signs and/or symptoms such as delusions or hallucinations, the appropriate diagnostic specifier is "Severe With Psychotic Features." In order to use the specifier "Moderate" the individual must have a severity of the disorder that is intermediate between Mild and Severe.

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Additionally, the doctor can specify if the Major Depressive Disorder is in some stage of remission, by using the diagnostic specifiers of "In Partial Remission" or "In Full Remission." "In Partial Remission" is the diagnostic specifier used if the full criteria for the disorder were previously met but at the time of the doctor's evaluation only some of the signs and/or symptoms remained. "In Full Remission" is the diagnostic specifier used if there are no longer any signs and/or symptoms of the disorder but that it is still clinically relevant to note that the person had those signs and/or symptoms. Finally, the doctor can use a specifier called "Unspecified" if they are uncertain about the severity or remission status of the disorder. However, the use of "Unspecified" in a medical-legal context raises the question of, "Why did the doctor choose to write their report without obtaining sufficient information to specify that nature of the disorder?"

<u>An inspection of the DSM-IV-TR reveals that the nine signs and/or symptoms are as follows</u>:

A. A depressed mood that is present most of the day and every day or nearly every day.

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B. A markedly diminished interest or pleasure in all, or almost all, activities most of the day, every day or nearly every day.

C. A significant weight loss or weight gain while not dieting and/or a decrease or increase in appetite every day or nearly every day.

D. Insomnia or hypersomnia every day or nearly every day, which is a lack of restorative sleep or an overabundance of restorative sleep.

E. Psychomotor agitation or retardation, that is, excessive motor activity or a slowing of body movements, respectively, every day or nearly every day.

F. Fatigue or a loss of energy every day or nearly every day.

G. Feelings of worthlessness and/or excessive or inappropriate guilt every day or nearly every day.

H. Diminished ability to think or concentrate or indecisiveness, every day or nearly every day.

I. Recurrent thoughts of death, recurrent suicidal thoughts without a specific plan, or a suicidal attempt, or a specific plan for committing suicide.

In addition to the above, the individual must also present with evidence that they meet four additional diagnostic criteria.

First, the patient must not meet the criteria for what is called a Mixed Episode. A Mixed Episode is present when the person exhibits rapidly alternating moods and meets the above-mentioned criteria for a Major Depressive Episode, every day or nearly every day, for at least one week and the criteria for a Manic Episode, every day or nearly every day, for at least one week. According to the DSM-IV-TR, a Manic Episode is defined as a distinct period of time during which the person shows an abnormally and persistently "elevated, expansive or irritable mood" for at least one week, or less if they are hospitalized. There are additional criteria that must be met to diagnose a Manic Episode correctly, but for our purposes we can stick with an "elevated, expansive or irritable mood." A full discussion of Manic Episodes can be found on pages 357 through 361 of the DSM-IV-TR, if you really are curious about the full set of criteria.

Second, the patient's signs and/or symptoms must cause them clinically significant distress or impairment in social, occupational or other areas of functioning, such as school.

Third, the signs and/or symptoms are not due to the direct physiological effects of a substance, such as a drug of abuse or a prescription medication, and they must not be caused by some general medical condition. For example, severe cases of hypothyroidism can mimic the signs and/or symptoms of a Major Depressive Disorder. If the signs and/or symptoms are caused by any of the above, it is not appropriate to diagnose a Major Depressive Disorder.

Fourth, the signs and/or symptoms are not better accounted for by Bereavement. In this regard, if the signs and/or symptoms begin within two months of the loss of a loved one, and do not last beyond two months, they are considered to be due to the death unless there is some marked functional impairment such as a morbid preoccupation with worthlessness, suicidal ideation or psychotic symptoms such as hallucinations or delusions.

Given that the diagnosing practitioner can determine if the Major Depressive Disorder is Single Episode or Recurrent, can distinguish between four levels of severity of the disorder or decline to discuss severity by reporting "Unspecified," and can note if the disorder is "In Partial Remission" or "In Full Remission," there are 14 basic different possible diagnoses of Major Depressive Disorders, each with a separate numerical diagnostic code. These are:

Major Depressive Disorder, Single Episode, Mild (296.21)
Major Depressive Disorder, Single Episode, Moderate (296.22)
Major Depressive Disorder, Single Episode, Severe Without Psychotic Features (296.23)
Major Depressive Disorder, Single Episode, Severe With Psychotic Features (296.24)
Major Depressive Disorder, Single Episode, In Partial Remission (296.25)
Major Depressive Disorder, Single Episode, In Full Remission (296.26)
Major Depressive Disorder, Single Episode, Unspecified (296.20)

Major Depressive Disorder, Recurrent, Mild (296.31)
Major Depressive Disorder, Recurrent, Moderate (296.32)
Major Depressive Disorder, Recurrent, Severe Without Psychotic Features (296.33)
Major Depressive Disorder, Recurrent, Severe With Psychotic Features (296.34)
Major Depressive Disorder, Recurrent, In Partial Remission (296.35)
Major Depressive Disorder, Recurrent, In Full Remission (296.36)
Major Depressive Disorder, Recurrent, Unspecified (296.30)

While there are many complications involved in correctly diagnosing a Major Depressive Disorder, at the very least, the individual must present with at least five of the nine signs and/or symptoms listed above in "A" through "I." Once that bridge is crossed then all of the other criteria must be considered. However, if at least five of those nine listed signs and/or symptoms are not found by the doctor then the diagnosis of a Major Depressive Disorder is not appropriate.

In conducting a psychological evaluation to determine if someone has a Major Depressive Disorder the doctor must follow the normal psychodiagnostic procedures by:

1. giving a Mental Status Examination
2. taking a complete life history including the patient's current complaints
3. administering a battery of objective psychological tests
4. reading the available medical records to see what other mental health practitioners have found
5. obtaining collateral sources of information in the form of interviews with the patient's relatives, friends and/or occupational associates

Major Depressive Disorders can be life-threatening. Research indicates that up to 15% of individuals who have a severe form of a Major Depressive Disorder die by their own hands, men more frequently than women. Individuals with chronic or severe general medical conditions, such as diabetes, heart attacks, cancer and strokes have an increased risk of developing a Major Depressive Disorder. According to the DSM-IV-TR, up to 20%-25% of such individuals will develop a Major Depressive Disorder during the course of these medical illnesses. Women are at greater risk for developing a Major Depressive Disorder than men. The lifetime prevalence in women varies from 10% to 25%, depending on the particular research study, whereas the lifetime prevalence in men is between 5% and 12%. The data also show that the rate of occurrence is not related to ethnicity, education, income or marital status. However, the average age of onset is the mid-20s.

The data also indicate that at least 60% of the individuals who present with a Single Episode of a Major Depressive Disorder will go on to have a second episode. Research also shows that after the second and third episodes the likelihood of an additional episode increases with each subsequent episode. The data further indicate that one year after the diagnosis of a Major Depressive Episode that only 40% of the patients no longer have some form of a DSM-IV-TR diagnosable Mood Disorder, or alternately, 60% of the patients still present with some form of a Mood Disorder. Additionally, an individual is 1 1/2 to 3 times more likely to develop a Major Depressive Disorder if a first-degree relative has had this disorder than is someone in the general population. Finally, research indicates that episodes of a Major Depressive Disorder often follow a severe psychosocial stressor such as the death of a loved one, a divorce, a major illness, or any other major aversive event in the patient's life.

The three basic treatments for Major Depressive Disorders are psychotherapy, medication, and electroconvulsive therapy (ECT), or as it is sometimes called, electroconvulsive shock therapy (EST). Generally speaking, psychotherapy and medication are the treatments of choice, while ECT is typically only used as a last resort on patients with severe and seemingly intractable depression. For most cases, care is usually given on an outpatient basis, while treatment in an inpatient facility is usually considered only if there is a significant risk to self or others.

The most researched form of psychotherapy for depression is cognitive behavioral treatment, which teaches patients a set of useful cognitive and behavioral skills. In this regard, cognitive behavior therapy is designed to change the behaviors and thoughts of a clinically depressed person. The major tenet of cognitive behavior therapy is that depressed people

are depressed because their thinking is biased towards negative interpretations. Accordingly, depressed individuals make negative evaluations of themselves, the world, and the future, which is the hallmark of a clinical depression, by making such self-statements as "what happened to me on the job is just awful and it will never get better." Treatment is typically aimed at exposing these unrealistic ideas and getting the patient to recognize their distorted nature and to adopt more positive approaches to their issues.

Research on prescription antidepressants reveals results that are comparable to those of psychotherapy, although more patients are likely to withdraw from such treatment than stop psychotherapy, probably because of undesirable side effects of the medication. Medications typically take weeks to begin to have an effect and the data indicate that when they work it can take at least six to eight weeks from the start of medication to when the patient is back to their normal self. Thereafter, the medication is usually continued for four to five months to minimize the likelihood of a recurrence. Selective serotonin reuptake inhibitors (SSRI's) such as Celexa, Lexapro, Prozac, Luvox, Paxil and Zoloft as well as tricyclic antidepressants such as Elavil, Anafranil, Sinequan, Tofranil, Pamelor and Vivactil have been shown to be effective in reducing the patient's symptoms. These medications typically have relatively mild side effects, and patients who do not respond to one SSRI can be switched to another with improved results.

Finally, electroconvulsive therapy (ECT), or as it is sometimes called, electroshock therapy (EST) involves administering pulses of electricity to the brain, under anaesthesia, which induces a seizure. Typically, the patient is given 6 to 12 treatments over a period of three to four weeks. This procedure is typically recommended for severe depressions, which have not responded to antidepressant medication and psychotherapy, and as such, some doctors believe that it is a treatment of last resort.

This is the eighth of a series of monthly newsletters aimed at providing information about psychological evaluations and treatment that may be of interest to attorneys and insurance adjusters working in the areas of workers' compensation and personal injury. If you have not received some or all of our past newsletters, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.

2009 Newsletters

February, 2009 –Litigation problems with the GAF
March, 2009 – Common flaws in psych reports
April, 2009 – The Minnesota Multiphasic Personality Inventory (MMPI)
May, 2009 – Apportioning psychiatric disability in workers' compensation cases and assessing aggravation in personal injury cases
June, 2009 - Subjectively interpreted projective psychological tests
July, 2009 – Sleep disorders and psychiatric injuries
August, 2009 – Posttraumatic Stress Disorder
September, 2009 – Computer Use Disorder