THE WETC PSYCHOLOGY NEWSLETTER

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What vs. Why: Determining Causality in Psych Cases

During my tenure as a professor, teaching psychology at the university level for 30 years, and in the last 25 years working as a clinician and a forensic psychologist in the areas of workers' compensation and personal injury litigation, I have encountered a recurrent theme or issue, which I believe is most conveniently referred to as the "What vs. Why" issue. From an academic point of view, the "What vs. Why" issue is usually referred to as the "causality issue" and typically "solved" by stating that correlation does not prove causality.

With regard to this "What vs. Why" issue, psychologists and psychiatrists are generally very good at answering the question "What?" but not necessarily very skilled at answering the question "Why?". Consider the APA's diagnostic manual, the DSM-IV-TR. A reading of this manual indicates that it contains a literally unknown number disorders, which are nevertheless very clearly defined. For each disorder in the manual there are some very specific criteria that must be met in order to diagnose that disorder correctly. For example, as I discussed in my newsletter of October, 2009, in order to diagnose any form of a Major Depressive Disorder correctly the individual must present with at least 5 of the following 9 signs and/or symptoms:

1. Depressed mood, most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss or weight gain when not dieting or a decrease or increase in appetite, nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day.

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6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.

Quite clearly, if the psychologist needs to answer the question, "What is wrong with this individual?" the existence of the diagnostic criteria in the DSM-IV-TR makes answering that question a relatively simple matter. Depending on the signs and symptoms presented by the patient, the results of psychological testing and a reading of their medical records, they either have or do not have a Major Depressive Disorder. Thus, the answer to the question, "What?" is straightforward. In fact, all the doctor or an attorney has to do is look at the patient's complaints or, as they are sometime called, symptoms; inspect the observational data collected during their Mental Status Examination and the remainder of the clinical interview; consider the objective psychological testing data; evaluate the contents of the patient's medical records and examine any available collateral sources from co-workers, friends and/or relatives. Simple!

On the other hand, answering the question, "Why does this individual have a Major Depressive Disorder?" is a much more complex question and one that may not have a definitive answer.

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Consider the recent case of a married gentleman who presented in my office with a considerable amount of information that left no doubt that he had a Major Depressive Disorder. Without going into his extensive history, I can tell you that the patient came to the attention of mental health professionals when the police responded to a domestic violence call alleging he had assaulted his wife. In conjunction with that call, the Psychiatric Emergency Team dispensed to the scene decided the husband was severely clinically depressed and needed to be involuntarily hospitalized, or 5150'd, as a danger to himself and others. Subsequently, he spent a relatively brief period of time in the hospital, was medicated for his depression and then released.

Now comes the difficult part. "Mr. Smith" as I will call him, was referred to my office for an Agreed Medical Evaluation which led to the question, "What produced the depression?" As it turns out, the gentleman's history and employment records indicate he was having some problems at work with what he portrayed as an abusive supervisor who was threatening to terminate his employment. In interviewing the patient I also determined that there were some marital problems at home prior to the onset of the difficulties at work. Thus, the problem of causality is complicated and can be phased as a series of almost unending questions. For example: Did a work problem produce a clinical depression leading to the assault? Did the marital problems produce a clinical depression leading to some occupational difficulties? Did something else produce the depression? Or, was it a combination of factors, and if so, what was the predominant cause? Of course, you will recognize this as a special case of, "Which came first, the chicken or the egg?" or "Are you beautiful because I love you, or do I love you because you are beautiful?".

Well, what's a psychologist supposed to do to answer that question? The answer is analogous to a real estate agent telling you that the price of a property is determined by "location, location, location." In this regard, there is no doubt that the cause of a disorder is best determined by "history, history, history." Only by exploring what led up to the disorder is it possible to determine the disorder's cause. In this regard, there are two main sources of data that are relevant; what the patient has to say and what the records have to say. (Psychological testing can also be helpful in establishing causality, although testing is usually not as important a source of information). Of course, the trick is to be able to separate the wheat from the chaff and to determine the credibility of both sets of data. In this case, it could be that the patient's marital problems led to his work problems and his depression. It also is possible that his work problems led to his marital problems and his depression or that some third and as yet unmentioned factor was the key ingredient. Obviously, if you are not involved in the case the cause is irrelevant. What is relevant is that we understand the possibilities and the nature of answering the "Why?" question. In Mr. Smith's case, the cause of his depression could be attributed to his childhood experiences, his marital problems, genetic factors, his boss's behavior and/or a variety of other psychosocial issues. Apportionment is obviously another tricky issue.

Another place where "What vs Why" comes up is in the area of psychological testing. As I talked about it in my newsletter of April, 2009 the principal test used in psychology is the Minnesota Multiphasic Personality Inventory (MMPI). One of the major benefits of the MMPI is that it yields objective data that speak directly to the issue of the patient's credibility and test taking attitudes. Depending on which version of the MMPI is used, there are different sets of multiple scales or measurements that allow the doctor to determine if the individual was exaggerating, embellishing or attempting to simulate symptoms during the examination. There are also objective data that can indicate if the patient was trying to portray themselves in an unrealistically positive manner. Taken as a group, those scales answer the question "What?" They tell us what the patient was doing during the testing, and to the extent that that finding is generalizable, what the patient was doing during the examination.

Unfortunately, although the data are quite good for answering the question "What was the patient doing during the examination?" they do not tell us "Why?" the patient was behaving in that manner. The answer to that question is open to interpretation. One theory or interpretation of what is sometimes called "faking bad" or "malingering" is that the person was "crying out for help." An obviously more tongue-in-cheek theory is that they were "crying out for excessive benefits." What's a doctor to do?

Again, the answer is "history, history, history" as well as "observations, observations, observations." In this regard, a person who is "crying out for help" would be expected to present with one or more of the following types of data:

1. objective signs from the doctor's Mental Status Examination of some psychopathology

2, at least some testing data indicative of psychopathology

3. the absence of evasiveness, vagueness or inconsistency during the clinical interview

4. a history of seeking some help for their problems either from a mental health professional or a religious counselor

5. the likelihood of regular attendance at psychotherapy or some form of counseling

6. the likelihood of taking some form of psychotropic medication on a regular basis

Simply summarily stating that the patient who was shown to be exaggerating, embellishing or attempting to simulate symptoms is not enough to draw any inferences about their psychological status, such as that they were either "crying out for help" or "malingering" or trying to collect unwarranted benefits.

In conclusion, in medical-legal evaluations, psychologists are often very good at determining what is wrong with an individual but they tend to flounder when attempting to discuss the cause of an individual's problem. Generally, when they have difficulties in this area, the root of the problem is an inadequate amount of data that has led to a failure to make a convincing case for the theory or hypothesis they have put forward in an attempt to explain what they have observed.

This is the twenty first 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.