THE WETC PSYCHOLOGY NEWSLETTER

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Dysthymic Disorder (300.4)

In the two plus years I have been publishing this newsletter I have talked about many subjects in psychology and psychiatry. All I have written about revolves around a single theme. It is important to demystify the contents of psychological and psychiatric reports in the medical-legal area. Specifically, insurance adjusters, applicant and plaintiff attorneys, defense attorneys, judges and physicians in other medical specialties should not be reading psychological and psychiatric reports and wondering, "What the hell does that mean?" If one is concerned with fair settlements on litigation, and you can put me in that category, it is reasonable to expect that all these professionals should be able to read a psych report and understand the doctor's conclusions and how they arrived at those conclusions.

This month I have singled out a Dysthymic Disorder (300.4), one of the DSM-IV-TR's Mood or Depressive Disorders, for discussion.

According to the DSM-IV-TR, a Dysthymic Disorder (300.4) is diagnosed correctly when the individual presents with a chronically depressed mood that occurs for most of the day, more days than not, for at least two years. During periods of a depressed mood, at least two of the following six additional symptoms are present: a poor appetite or overeating, insomnia or hypersomnia (too much sleeping), a low energy level or fatigue, low self-esteem, poor concentration and/or difficulty making decisions, and feelings of hopelessness. In the case of an Early Onset Dysthymic Disorder the onset of the dysthymic symptoms occurs before the age of 21. If the onset of the dysthymic symptoms is after the age of 21 the correct diagnosis is a Late Onset Dysthymic Disorder.

How do you know if there is sufficient evidence in the doctor's report to diagnose a Dysthymic Disorder correctly? Well, the answer is to read the report and look for the following pieces of data or information.

"in order to diagnose a Dysthymic Disorder correctly the doctor must present supporting data from at least the patient's life history and their presenting symptoms or complaints and the results of their face-to-face Mental Status Examination."

Specifically, every psych report should have a description of the patient's current complaints or, as they are sometimes called, symptoms, that is based on the face-to-face interview conducted by the doctor. Accordingly, that history should be quite clear in stating that during the clinical interview the patient presented with a history of having been depressed for at least two years and the depression has been present most of the day, more days than not.

Now clinical depression can present in a variety of ways. In fact, when a patient appears in my office and reports they are depressed I know that is just the beginning of our discussion. I always say to them something like, "Mr. Smith, I've been doing this for many years and one of the things I am certain of is that different people who tell me they are depressed often mean very different things, so I have to ask you exactly what you mean when you tell me you are depressed."

In fact, people who are clinically depressed may present with a variety of complaints such as: thoughts and feelings of worthlessness, helplessness, hopelessness, self-reproach, guilt, pessimism, failure, incompetence, a loss of interest in pleasure, difficulty thinking, difficulty making simple decisions, demoralization and thoughts of death and/or suicide. They may also report symptoms of fatigue, frustration, weight changes when not dieting or attempting to gain weight, bodily aches not due to any known physical pathology, decreased energy, frustration over minor matters, insomnia, anger and/or a decreased libido or loss of sexual activity. Obviously, without putting words or ideas in their mind, it is the responsibility of the evaluating doctor to determine precisely what they mean in terms of these complaints when they say, "I'm depressed." Most importantly, that information should find its way into the

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doctor's report along with data about the specific manner in which they experience those complaints, that is, their qualitative nature, as well as the frequency, intensity, onset, duration and course of those complaints. Essentially, that is what it means to take and provide a complete history of the patient's complaints.

Additionally, in the case of the correct diagnosis of a Dysthymic Disorder when the person is depressed there must be at least two or more of the following: a poor appetite or overeating, insomnia or hypersomnia, a low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions and/or feelings of hopelessness. That history should also be in the doctor's report. If the history doesn't match the DSM-IV-TR definition of a Dysthymic Disorder, the doctor's report must be considered to be substantially flawed.

In addition to the patient's complaints, the patient must present in the doctor's office with signs of a clinical depression. Signs are different than symptoms in that signs are what is actually observed by the doctor during their face-to-face interview. In this regard, the doctor should, and almost invariably does, conduct a Mental Status Examination. A Mental Status Examination produces a set of observations that are made by the doctor, under reasonably controlled conditions, employing a relatively standard set of examining techniques and questions. These procedures yield easily reported upon objective data. These data are at least partially in the form of specific narrative statements made by the patient that indicate they are depressed such as, "I just don't feel like I want to go on." The Mental Status Examination data also may reveal specific behavioral deficits indicative of a depression such as psychomotor retardation or agitation (a general slowing of body movements or excessive motor activity, respectively), reduced cognitive functioning, deficits in attention, deficits in memory, sadness, tearfulness, looking as if they are about to cry, irritability, indecisiveness and social withdrawal. All of these are observable during a face-to-face interview and easily described in the doctor's report.

Additionally, there may be objective psychological testing data indicative of a clinical depression. In this regard, the Minnesota Multiphasic Personality Inventory (MMPI) is the gold standard for determining the existence of psychopathology. In this regard, you can check out my newsletters of April, 2009 and May, 2010. If you don't have copies, just email us and we'll send them to you. Additionally, we hope to have them on a website in the next few weeks. Also, you might wish to note that I said that there "may be objective psychological testing data indicative of a clinical depression," with the emphasis on "may" since there are cases when the testing is not capable of providing credible information about a patient's psychological status.

Finally, evidence of a clinical depression can come from the doctor's review of the patient's medical records and any collateral sources of information that might exist. In this regard, one should ask, "Did the doctor find any records indicating that any mental health professional concurred with their conclusion that the patient has been depressed, more days than not, for a period of at least two years?" Similarly, did the doctor have any data from any collateral sources of information in the form of interview data collected from the patient's friends, relatives and/or co-workers that support their diagnosis and conclusions? However, the absence of medical records and collateral sources of information is not definitive as there simply may not be any such data.

In summary, in order to diagnose a Dysthymic Disorder correctly the doctor must present supporting data from at least the patient's life history and their presenting symptoms or complaints and the results of their face-to-face Mental Status Examination. In addition, there may be some supportive findings from the objective psychological test battery, the patient's medical records and collateral sources of information in the form of interviews with the patient's friends, relatives and co-workers. The sum of those data must indicate that the patient has been clinically depressed, more days than not, for at least two years with at least two of six attendant symptoms. If the doctor hasn't done so, they haven't produced a credible conclusion and everyone who is dependent on their report for information about the patient should be aware of that status.

This is the twenty-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.