THE WETC PSYCHOLOGY NEWSLETTER

Dr. Bruce Leckart

"Find the Truth, Tell the Story"

Westwood Evaluation & Treatment Center
11340 Olympic Blvd., Suite 303, Los Angeles, CA 90064
310-444-3154, DrLeckartWETC@gmail.com, www.DrLeckartWETC.com

April, 2016
Volume 1, Issue 87

Clinical Depression

Everybody gets depressed. However, it is only when that depression is not normal, reasonable, understandable and expectable that it crosses the border and becomes a disorder. There are many psychological disorders in the DSM-IV-TR that include signs and symptoms of a clinical depression. Thus, if you are interested in the litigation of psychological claims it is important to know how depression is observable during a psychological evaluation and what to look for in a psych report to see if the author "gave away the store."

Clinical depressions and DSM-IV-TR psychological disorders are normally diagnosed after examining as many as five different data sources. These sources of data are: the patient's life history and their presenting symptoms or complaints, the doctor's report of their Mental Status Examination, the results of an 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.

Symptoms of a Clinical Depression

The word "symptoms" is synonymous with the word "complaints." Thus, the first source of data on depression is what the patient says is wrong with them. Individuals who are clinically depressed may complain of one or more feelings, thoughts and beliefs of worthlessness, helplessness, hopelessness, self-reproach, guilt, pessimism, failure, incompetence, a loss of interest in pleasure, difficulty thinking, difficulty making simple decisions,

If in reading a psych report you find reason not to trust its credibility you can send it to me for a thorough analysis.

demoralization and thoughts of death and/or suicide. They also may report symptoms of fatigue, frustration, weight changes when not dieting or attempting to gain weight, bodily aches, decreased energy, frustration over minor matters, insomnia, anger and/or decreased libido. There are so many different complaints that are indicative of a clinical depression that it is very unlikely to find two individuals who have exactly the same complaints. This is especially true when one considers that even if two individuals have exactly the same complaint, say of low self-esteem, what they mean by low self-esteem, that is, the qualitative nature of that complaint, as well as it's frequency, intensity, duration, onset and course over time are likely to be different.

Signs of a Clinical Depression

The word "signs" is used to denote what the doctor observes about an individual. Thus, the signs of a clinical depression are what the doctor observed during their face-to-face contact that indicates the patient is depressed. As you should expect, the signs of a clinical depression often are highly consistent with the symptoms of a clinical depression although the doctor may observe some signs that the patient does not complain about. In particular, during the face-to-face interview the patient may be observed to express feelings, thoughts and beliefs very much like what they complained about. For example, in the case of low self-esteem the patient may be observed to say something quite simple such as, "I just hate myself and my life."

The doctor also gives the patient a Mental Status Examination. For the uninitiated, a Mental Status Examination produces a set of observations made by the doctor using a relatively standard set of examining techniques and questions. Some of those techniques and questions are very simple, like asking the patients to solve simple arithmetic problems in their heads, count backwards by sevens from 100 or recall objects pointed out in the examination room after an interval of a few minutes. In this regard, a depressed patient may exhibit such signs as reduced cognitive functioning, deficits in concentration, irritability, indecisiveness and/or social withdrawal, all signs of a clinical depression, some of which the patient may not be aware of and therefore unlikely to talk about when taking a history of their complaints.

Psychological Testing

There are untold thousands of psychological tests. Anyone can write a test for anything and lots of people do. You can find them in magazines and newspapers. However, in order for a test to be useful in diagnosing a psychological disorder that instrument must have demonstrable validity and reliability. Validity means that the test has been shown to be capable of measuring what it is supposed to measure. Reliability means that the test will come up with the same conclusion for a given individual, each time it is administered. The Gold Standard for psychological testing in the medical-legal area is the Minnesota Multiphasic Personality Inventory (MMPI), which has been around in one version or another for a little over 70 years. This test is not only a valid and reliable measure of psychopathology but it is also capable of determining if the person has answered the questions in an honest and frank manner. The MMPI generates a large number of interpretable scores on different dimensions or "scales." One of the basic "scales" is the Depression Scale. This scale is known to be highly sensitive to the existence of a clinical depression that can be presented to the court. Now before leaving this topic lets just make it clear that there are many tests that purport to measure depression but the vast majority of them have no way of determining if the person completed the test honestly so they are completely useless in a medical-legal context.

Medical Records

The fourth source of information about a clinical depression is the patient's medical records. This is very simple. The doctor simply looks at the patient's medical records, documents created by other physicians either in the context of a hospitalization or a private practice. If that doctor has done a good job in documenting the patient's psychological status that is supporting evidence for diagnosing a clinical depression. If the doctor has not done a good job……well. One caveat about medical records is the training and qualifications of the person creating the records. As a psychologist I do not believe that anyone would accept my diagnosis of an orthopedic disorder. Thus, it should be clear that it is not reasonable to accept a diagnosis of a clinical depression provided by an orthopedist.

Collateral Sources of Information

Collateral sources of information come in the form of interview data collected from the patient's friends, relatives and co-workers. In medical-legal cases it is very unusual to have collateral sources of information. The only times I've ever used such sources has been in cases where the individual is not capable of being examined or of providing a cogent history. Psychological autopsies frequently use collateral sources of information where the question is, "Was the person depressed before they died?" Similarly, if the person is non-communicative because of having had a debilitating cerebral stroke or is severely developmentally disabled then it is reasonable to use collateral sources. In thirty years of practice I have used collateral sources in less than one case in a thousand.

In summary, everyone gets depressed but it is only when that depression goes beyond what is normal, expectable, reasonable and understandable is it reasonable to diagnose some form of a clinical depression. That diagnosis in itself is based upon the patient's complaints, the doctor's observations, the psychological testing data, the patient's medical records and rarely the information collected from friends,

relatives and business associates. However, there are innumerable possible psychological disorders in the DSM-IV-TR so after determining that the patient is clinically depressed the next step is deciding which disorder best describes their condition. But without the supporting data, any diagnosis is meaningless!

FREE pre-deposition consults involving reports of a

·QME ·PQME ·AME ·AQME

(e-mail us at DrLeckartWETC@gmail.com for more information)

This is the eighty-seventh of a series of monthly newsletters aimed at providing information about pre-deposition/pre-trial consultations, 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 listed on the next page, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.