THE WETC PSYCHOLOGY NEWSLETTER

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"Find the Truth, Tell the Story"

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The Magic of Operational Definitions

The key to writing a competent medical-legal report is the concept of an operational definition. Very simply, an operational definition is a simple definition of the operations or procedures that have to be performed to measure anything of interest. In medical-legal psych reporting the magic of an operational definition is that it provides the operations that have to be performed to arrive at a correct diagnosis.

All psychological disorders are operationally/clearly defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) by a set of criteria that must be met in order to conclude that a plaintiff or an applicant has ever suffered from the disorder diagnosed by the doctor.

Please bear with me while I tell you that the DSM-IV-TR defines a Major Depressive Disorder as a severe Mood Disorder characterized by a pervasive clinical depression and a series of associated symptoms. As stated in the DSM-IV-TR, Major Depressive Disorders fall into one of two categories: Recurrent or Single Episode versions of the disorder. A Recurrent disorder is diagnosed correctly when the individual presents with a history of having had two or more Major Depressive Episodes. A Single Episode version is diagnosed correctly when the individual has had only one Major Depressive Episode. Additionally, a Major Depressive Disorder is diagnosed correctly when the individual presents with at least five of nine specific symptoms or complaints. In addition to having at least five of nine symptoms, the patient must present with Symptom 1 and/or Symptom 2. Further, the doctor must identify the severity of the disorder according to the specific criteria outlined in the DSM-IV-TR. Specifically, if the patient presents with five or six symptoms, the diagnostic modifier "Mild" is used in specifying the disorder. If the individual presents with most of the nine symptoms as well as "clear-cut observable disability" (e.g., inability to work or care for children), the correct diagnostic modifier is "Severe Without Psychotic Features." If they present with hallucinations and/or delusions the correct diagnostic modifier is "Severe With Psychotic Features." In order to use the modifier "Moderate," the patient must present with a severity of the disorder that is intermediate between Mild and Severe or present with more than five or six depressive symptoms. A reading of the DSM-IV-TR indicates that the nine possible symptoms of a Major Depressive Disorder are:

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.
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.

TO BE VERY CLEAR, THERE IS ABSOLUTELY NO AMBIGUITY IN THE DIAGNOSTIC CRITERIA. WHEN THE DOCTOR EXAMINES THE PLAINTIFF OR THE APPLICANT THE DATA, OR INFORMATION, THEY COLLECT OR HAVE ON HAND FROM OTHER SOURCES EITHER SUPPORTS OR DOESN'T SUPPORT THE DIAGNOSIS.

WHAT COULD BE SIMPLER?

THE FIVE SOURCES OF INFORMATION THE DOCTOR USES

There is virtually no disagreement in the medical community that there are five sources of information the doctor uses to arrive at their diagnosis of a Major Depressive Disorder, or any other disorder in the DSM.

1. the patient's life history and their presenting symptoms or complaints
2. the results of the doctor's Mental Status Examination
3. the results of a battery of objective, valid and reliable psychological tests
4. the plaintiff or applicant's medical records
5. any interviews the doctor may have with the plaintiff's or applicant's family, friends or colleagues

The bottom line here is that using the operational definition of any DSM-IV-TR disorder the doctor must take and report on the examinee's history of their symptoms or complaints providing the reader of their report specific information obtained from the patient demonstrating that the examinee has met the diagnostic criteria. In the case of a Major Depressive Disorder, the doctor's report must demonstrate that the patient has a depressed mood, most of the day, nearly every day. Remembering the meaning of an operational definition, this is done by the very simple procedure of asking the patient to describe what they mean when they say they are "depressed."

In the case of a truly clinically depressed person they will describe themselves as feeling some or all of the following: worthless; helpless; hopeless; self-reproachful; guilt ridden; pessimistic; having feelings, thoughts and beliefs they are a failure; feeling incompetent; experiencing a loss of interest in pleasure; having difficulty thinking and/or making simple decisions; feeling demoralized and having thoughts of death and/or suicide. Additionally, clinically depressed people often 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. A competent mental health evaluator will report that the patient described their thoughts, feelings and/or beliefs with some or all of the above.

In addition to those descriptions, a competent mental health evaluator will follow the very simple procedure or operation of asking the patient to describe how often they have those feelings, thoughts and/or beliefs. They will also follow the procedure or operation of measuring the intensity of these characteristics, typically by asking the patient to rate themselves on a ten-point subjective intensity scale. The doctor will also continue their procedures or operations by asking the patient to describe how long those depressive symptoms last when they occur, all day? every day? once in a while? twice a week? etc. Similarly, the doctor will follow the procedure or operation of asking when these symptoms first began. Finally, the examiner will ask about the course of these symptoms. Have they been constant since their onset? Have they fluctuated over time? etc. etc. That is what it means to take a complete history of the patient's symptoms or complaints. Without all of the above information, the doctor's report is deficient and they have not operationally or clearly defined the patient's symptoms or complaints that conforms to a diagnosis of a Major Depressive Disorder. Good enough reason to throw out the doctor's report?

In addition to taking the history, as described above, the doctor must give a Mental Status Examination. A Mental Status Examination produces a set of observations of the patient, which are made by the doctor, under reasonably controlled conditions, employing a relatively standard set of examining techniques and questions. Specifically, the doctor must measure the patient's mood, memory, concentration, insight and judgment. Clinically depressed individuals often appear with psychomotor retardation or agitation, reduced

cognitive functioning, deficits in attention, sadness, tearfulness, looking as if they are about to cry, irritability, indecisiveness and social withdrawal. They also will typically present with deficits in one or more areas of memory, concentration, insight and judgment.

The competent evaluating physician must also obtained objective psychological testing data showing that the patient is a credible historian and has the psychopathology the doctor has diagnosed. The major tests for assessing credibility and psychopathology are the Minnesota Multiphasic Personality Inventory (MMPI), the Millon Clinical Multiaxial Inventory (MCMI) and the Cattell Sixteen Personality Factor Test (16PF). All three of these tests generate objective scores that should always appear in the doctor's report and presented to the court.

The other operations or procedures that are sometimes available are the patient's medical records and interview data collected from their relatives, friends or colleagues, although frequently these data are not available.

These simple procedures or operations of following the DSM-IV-TR definition of any given disorder and obtaining historical information, Mental Status Examination data, psychological testing scores and medical record and collateral sources of information are the essential aspects of any medical-legal psychological or psychiatric report. If these procedures or operations are not followed the contents of the doctor's report is worthless with regard to assessing the patient's claim of a psychiatric injury.

If you have a report that you believe is operationally deficient you can get my professional opinion for free by emailing me the report at DrLeckartWETC.com or calling me at 844-444-8898. I'll tell you where the flaws are and at that point you can consult my website at www.DrLeckartWETC.com and use the free resources found there to plan your strategy and develop a series of Cx questions to dismantle the doctor's report or ask me to write a report doing it for you. Either way, I'll be happy by furthering my crusade against worthless, flawed psychological reports!

This is the one hundred forty-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, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.