THE WETC PSYCHOLOGY NEWSLETTER

Dr. Bruce Leckart

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

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COMMON FLAWS IN PSYCH REPORTS

After spending 24 years reading medical-legal psych reports it is very obvious that most of them contain substantial flaws. Unfortunately, since SB899, AME and Agreed Panel QME reports are usually not reviewed by other doctors. Nevertheless, these reports contain substantial flaws that usually are not discovered in time for an MSC or during an AME's deposition or trial testimony. Regrettably, when unrecognized and allowed to stand, these mistakes hurt your client's final settlement, sometimes adversely affecting the applicant and sometimes the defense. **This month's WETC Newsletter is designed to help you find these flaws and produce better settlements for your clients.***

The conclusions expressed in psych reports are based on the collection of as many as five sets of data. These data sets are: the applicant's history as taken by the doctor, the doctor's Mental Status Examination, the psychological test data, the applicant's medical records and sources of collateral information in the form of interviews with the applicant's relatives, friends and co-workers. Keeping it brief, I'll just talk about the first three in this newsletter.

As everyone knows, the DSM-IV-TR is the "bible" for diagnostic work in psychology and psychiatry and is required for use by LC 3208.3 and the Psychiatric Protocols, which establish minimal standards for psychological and psychiatric evaluations and reports. **The best thing about the DSM-IV-TR is that it lists the specific diagnostic criteria, in plain English, which the doctor must observe in order to diagnose a disorder correctly.** For example, in order to diagnose any form of a Major Depressive Disorder, the applicant must present with at least 5 of 9 complaints, or what are often called symptoms.

Major Flaw Number One. A lack of correspondence between the history presented by the doctor and the DSM-IV-TR diagnostic criteria.

In order for a report to be credible the doctor's diagnosis **must** correspond to the DSM-IV-TR diagnostic criteria. Quite simply, if there are insufficient symptoms or complaints in the doctor's history of the applicant's complaints to diagnose the disorder correctly, the report is not credible. **Thus, to determine if there are sufficient complaints to diagnose a disorder all one has to do is put the list of the complaints attributed to the applicant**

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next to the DSM-IV-TR criteria and see if they match! If they don't, the doctor has not provided substantial evidence that the disorder exists.

Additionally, the doctor must do more than provide a simple list of complaints. They cannot simply say that the patient complained of "depression." A history of the applicant's complaints needed to arrive at and support a diagnosis must contain a description of the qualitative nature of those complaints, i.e., an answer to the question of the way in which the "depression" exhibits itself in the applicant's thoughts, behavior and feelings. There must also be what I call information about FIDO, the complaint's frequency (F), intensity (I), duration (D) and onset (O). Without all of this supporting information there is no substantial evidence of the disorder the doctor has "diagnosed."

Major Flaw Number Two. A lack of correspondence between the Mental Status Examination data presented by the doctor and the DSM-IV-TR diagnostic criteria.

A Mental Status Examination produces a set of observations that are made by the doctor using a reasonably standard set of examining techniques and questions. In order for a report to be credible there must be data in the doctor's report of their Mental Status Examination results indicating that the applicant's clinical presentation conforms to the DSM-IV-TR diagnostic criteria.

For example, in the case of a Major Depressive Disorder it is important to note that individuals who are clinically depressed often present with themes in their narrative of worthlessness, hopelessness, helplessness, incompetence, self-reproach, guilt, pessimism, failure, a loss of interest in pleasure, demoralization and thoughts of death and/or suicide. These individuals often talk about fatigue, weight changes when not dieting or attempting to gain weight,

Email us:
DrLeckartWETC@gmail.com

insomnia, frustration, anger and/or a decreased libido. Behaviorally, they often appear with reduced cognitive functioning, psychomotor retardation or agitation, attention deficits, sadness, tearfulness, irritability, indecisiveness and evidence of social withdrawal. All of these behaviors can be observed during a Mental Status Examination and some of them, like attention deficits, can be measured with specific techniques that yield easily reported upon data. **If there are no such Mental Status Examination data that specifically state what the doctor observed, but instead just a summary conclusion such as the "patient appeared depressed," or something vague like "the patient exhibited a depressed feeling tone," the doctor's report is substantially flawed.**

Major Flaw Number Three. The failure to provide objective psychological test data supporting the doctor's diagnosis.

Psychological testing, if the tests used are valid and reliable, is the only part of a psych report that is capable of generating objective data in the form of scores that can be taken into court and presented to the judge where it is possible to say, for example, "Here are the objective data that demonstrate that the applicant has a Major Depressive Disorder." Unfortunately, this is not usually done. **There are a multitude of flaws in psychological testing, too many to discuss in just one WETC Newsletter, so I'll just list some of them here and hopefully continue with this discussion at a later time.**

a) The Use of Subjectively Interpreted Tests

b) The Use of Tests That Are Lacking in Validity and/or Reliability

c) The Use of Tests That Are Incapable of Assessing Credibility

d) The Failure to Administer Any Psychological Tests At All

e) The Failure to Report Crucial Psychological Testing Data

f) The Gross Misinterpretation of The Data

g) Administering the Psychological Tests Under Non-Standardized Conditions

h) Administering Tests That The Test's Authors Have Stated Were Not Designed to Measure Psychopathology

i) Reporting Scores on Tests Such as the MMPI That An Applicant Cannot Possibly Obtain

Unfortunately, there are many other flaws that I have not discussed that find their way into psychological reports ……but that's a story for another day. Clearly, what is in order at the current time is for attorneys on both sides of the case, as well as judges and adjusters, to review their psych reports carefully, or get a professional to do it for them, before signing on the dotted line. **Of course, the best way of protecting your client's interests is to find and use a doctor who doesn't write substantially flawed reports.**

* For the most part, this discussion was taken from my recently published book, Psychological Evaluations in Litigation: A Practical Guide for Attorneys and Insurance Adjusters.