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

March, 2011
Volume 1, Issue 26

How to Cx a Shrink

Applicant and defense attorneys both have a good feel for the strength and weaknesses of their cases. Thus, it's not surprising when they get upset over erroneous conclusions found in AME and PQME psychological and psychiatric reports. However, attorneys often do not have enough information about the weakness in psych reports to effectively Cx the doctor. That's where I come in. For a few years I have been providing expert witness testimony for applicant and defense attorneys identifying the flaws in AME and PQME reports and providing suggestions about how to Cx the doctor. In fact, I think this service is so important for the medical-legal community that if a written report is not required, I will be happy to review any AME or PQME report for a free telephone consultation! But first, let's see if I can give you some useful tips that will allow you to do the job without my help.

Applicant and defense attorneys get upset over psych reports for different reasons. For applicant attorneys their complaint often is that the doctor found no compensable psychological disorder, and therefore no psychiatric injury, in cases where the attorney is virtually certain that conclusion is incorrect. Sometimes their dissatisfaction occurs because the doctor has found a compensable psychological disorder but no, or very little, psychiatric disability in the form of a Global Assessment of Functioning (GAF) score. At other times, they think that too much apportionment has been allotted.

As you might expect, defense attorneys typically get upset because of the opposite kinds of findings. Specifically, they often believe that the psychologist or the psychiatrist has written a report containing diagnoses that do not exist, or are greatly exaggerated, and/or the doctor has given the applicant a Global Assessment of Functioning (GAF) score that is unwarrantedly excessively low, leading to a Whole Person Impairment (WPI) rating that is excessively high. They also get upset when "not enough" apportionment is found.

Here is some information that may help Cx shrinks. Essentially, what you have to know is where to approach the doctor, i.e., where are the weaknesses in most psychological reports.

Email us:
DrLeckartWETC@gmail.com

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The Major Weakness in Psychological Reports

The major weakness of almost every flawed psychological or psychiatric report is the doctor's diagnosis or the lack thereof. In this regard, it is important to understand the process by which a doctor arrives at a DSM-IV-TR diagnosis. Essentially, doctors may consider as many as five different sources of information, but always at least the first three listed below. The five sources of information are:

1. The patient's history and presenting complaints
2. The doctor's Mental Status Examination observational findings
3. The objective psychological testing data
4. The doctor's review of the medical records
5. Any collateral sources of information in the form of interview data collected from the patient's friends, relatives or business associates.

As noted above, another source of substantial flaws is an erroneous GAF score. From the defense attorney's point of view the doctor has been too generous in providing a low GAF score. From the applicant attorney's point of view the doctor has been too conservative or "stingy" in estimating the GAF. And, of course, there is always the issue of apportionment.

Cx From an Applicant Attorney's Point of View

The process of developing a strategy to Cx a shrink from this perspective is fairly straightforward and involves demonstrating that the doctor has failed to find a disorder and a disability that is present. Here is the basic strategy. First, you determine what the doctor has diagnosed or their

"non-diagnosis." Second, you look up the specific DSM-IV-TR diagnostic criteria that must be met in order to diagnose the disorder or the "non-disorder" correctly. Third, you see if there are sufficient data in the doctor's report to meet the DSM-IV-TR diagnostic criteria. However, the greater problem for applicant attorneys is to find fault with a doctor who like the three famous monkeys sees no evil (disorder), hears no evil (disorder) and speaks no evil (disorder). Here are some suggestions.

One problem that is particular vexing to applicant attorneys is an AME or a PQME who "washes the patient out." There are a variety of methods for doing so, such as finding a pre-existing disorder like a Personality Disorder that obviously is not due to industrial factors and has not been aggravated by industrial events. A second problem is a doctor who has found a disorder but no disability, just a limited GAF score. A third is a doctor who has found "No Disorder or Condition." A fourth method involves diagnosing a "V Code," which is not a disorder and therefore does not constitute a psychiatric injury as defined by Labor Code section 3208.3.

Let's see how these issues might be dealt with during the course of a deposition.

First, let's take a look at Personality Disorders. As discussed in my newsletter of January, 2011 Personality Disorders are lifelong patterns of perceiving, relating to and thinking about the world and oneself that causes significant functional impairment and/or subjective distress, often in the form of depression and anxiety. Personality Disorders are <u>not</u> produced by industrial events. If an AME or PQME has diagnosed a Personality Disorder the basic question is, "Has the doctor provided sufficient data to coincide with the DSM-IV-TR diagnosis of the Personality Disorder they have diagnosed?" If they have not, their report is substantially flawed.

The first step that must be taken prior to a Cx is to find out if the Personality Disorder diagnosed actually appears in the DSM-IV-TR. Surprisingly enough, some doctors use outdated diagnostic manuals or "create" their own Personality Disorders. Of course, this is a "no-no." However, once it has been determined that the doctor has diagnosed a Personality Disorder that can be found in the DSM-IV-TR, the basic strategy is to determine if they have sufficient data to diagnose such a disorder and, if not, to go on to show that the signs and symptoms that are in their report are due to some disorder that is compensable.

Demonstrating that there is no Personality Disorder is <u>not</u> the same as proving that men on Mars do not exist. Here the most appropriate approach is to examine the data in the doctor's report and show that they have mistakenly interpreted that information. The strategy is quite straightforward. While in last month's newsletter I outlined the basic nature of the eleven different Personality Disorders found in the DSM-IV-TR, there is not enough information in that newsletter to use during a deposition. Thus, the first step is to obtain the detailed criteria from the DSM-IV-TR for the specific Personality Disorder that was diagnosed. Then, one must examine the various sets of data found in the doctor's report and ask the doctor questions that ultimately lead to the conclusion that there is no evidence of the Personality Disorder they have diagnosed. As noted above, since Personality Disorders are often characterized by significant anxiety and depression, once having shown that the Personality Disorder diagnosis is not correct, the attorney can look for information in the doctor's report or their deposition testimony that indicates that a compensable DSM-IV-TR disorder was present and not diagnosed. In this regard, if the doctor has diagnosed a Personality Disorder there will often be signs and symptoms of some psychological dysfunction. The key here is to show that the doctor has erred in diagnosing the Personality Disorder when the patient's clinical depression or pathological anxiety is due to a compensable Depressive Disorder or Anxiety Disorder. Of course, the first step is to show that the Personality Disorder diagnosis is wrong.

As noted above, the second problem for applicant attorneys is the doctor who has found a disorder but has concluded there is no compensable permanent psychiatric disability by providing what the applicant attorney believes is an unrealistic GAF score of 70 or more. Here the basic strategy is to show that the GAF score is inappropriate. One does this during the Cx by demonstrating that the doctor actually has data that would show that the patient had some occupational dysfunction, and that when the doctor's data are considered a GAF of 70 or greater is simply wrong. This can be done by consulting page 34 of the DSM-IV-TR and finding a GAF score that appears to meet the level shown by the patient and asking pointed questions that show that the doctor's data actually meet the definition of that GAF score. I have provided the DSM-IV-TR GAF definitions for scores of 50, 60 and 70, below. Another strategy is to provide the doctor with data that they did not have when they examined the patient that shows some occupational dysfunction not previously seen by the doctor.

A GAF of 70 is defined as:

Some mild symptoms (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**

A GAF of 60 is defined as:

Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panics attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).

A GAF of 50 is defined as:

Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).

A reading of the definitions of these scores indicates that the GAF can be derived by looking at the applicant's signs and symptoms, "**OR"** the level of impairment they show in occupational functioning. The word "**OR**" is the key. For example, a GAF of 60 can be correctly specified if the individual shows such symptoms as flat affect, circumstantial speech and/or occasional panic attacks. These are relatively serious symptoms that a person with a real psychiatric disability may or may not actually exhibit. However, given the presence of the word "**OR**," a GAF of 60 also can be correctly specified if the individual shows some "moderate difficulty" in occupational functioning where this is demonstrated by having conflicts with co-workers. Here a good strategy is to get the doctor who is being Cx'd to accept the definition of "moderate difficulty" in occupational functioning as being shown by such signs as conflicts with co-workers. One way is to work backwards and ask the doctor if they believe that problems that you can document would constitute a "moderate difficulty." Attorneys know how to do this!

Essentially, when it comes to the GAF scale you often can get very different pictures of an applicant if you look at their signs and symptoms as compared to their occupational functioning. When this occurs, the DSM-IV-TR, as well as the Schedule for Rating Permanent Disability (SRPD) provides a method for dealing with this discrepancy. This is discussed on pages 32 and 33 of the DSM-IV-TR as well as on page 1-13 of the SRPD. In this regard, a reading of the DSM-IV-TR reveals that it states, "It should be noted that in situations where the individual's symptom severity and level of functioning are discordant, the final GAF rating always reflects the worse of the two." Thus, according to DSM-IV-TR standards, if the individual has difficulty in occupational functioning that leads to a lower GAF score than what their signs and symptoms might suggest, the GAF score produced by examining their occupational functioning is the correct score to be used.

Of course, another basic issue is, "How well does the GAF score and the WPI reflect the applicant's actual psychiatric disability?" In this regard, it is entirely conceivable that a patient may have a GAF score as small as 40, with an associate WPI rating of 51 and yet may have sufficient behavioral signs and symptoms to allow for the reasonable conclusion that they would not be able to function outside of a sheltered workshop. Wouldn't this warrant the conclusion that they were totally psychiatrically disabled?

A third strategy that is especially useful if the AME or PQME doctor has found no disorder is to show that they have overlooked a variety of data that supports the existence of a disorder and a permanent psychiatric disability. In this regard, one set of relevant data is the reports produced by the treating psychologist and/or psychiatrist. In those reports you will typically find data supporting the treating doctor's diagnosis. Most importantly, if you have the treating doctor's case or treatment notes these should document what has occurred at every specific therapy session. If the doctor has kept careful notes, they can be used to show that the patient had many more signs and symptoms than found by the AME or PQME. At that point you can question the doctor being deposed concerning why they did not find the data or observations cited by the treating doctor or how they would explain the discrepancy between their observations and those of the treating doctor. On the way to establishing this point you will want to get the AME or PQME to agree that while they may have spent two hours in a face-to-face interview with the patient that the treating doctor or doctors may have spent scores of hours over months or years observing the patient and making their notes. Explaining the discrepancy between the treating doctor's notes and the evaluating physician's medical-legal report will not be easy for the AME or PQME!

Another way for an AME or PQME not to find a disorder is simply not to look in the places where it might be found. Here you might want to inquire about the comprehensiveness of the examination's elements, such as in the Mental Status Examination, the taking of the patient's history, or the validity and reliability of the doctor's psychological tests, or often the lack thereof. One strategy is to get the doctor to explain in detail what specific face-to-face interview techniques they used.

Finally, for our purposes we should consider "V-Codes," yet another story. There are many of them and perhaps I'll do a newsletter on them in the near future. Essentially, V-Codes are conditions or problems that may become a focus of clinical attention, i.e., evaluation and treatment, but by definition are not DSM-IV-TR psychological disorders. Accordingly, when a doctor "diagnoses" a V-Code, they are stating that since the applicant has not had a psychological disorder they have not had a psychiatric injury as defined by Labor Code section 3208.3.

One V-Code that often leads an AME or PQME to conclude that the patient has no DSM-IV-TR psychological disorder, no psychiatric injury, and no permanent psychiatric disability is an Occupational Problem (V62.2). Occupational Problems are a category used to classify individuals who have problems on the job but no mental disorder. One reason for diagnosing an Occupational Problem is "job dissatisfaction." Here one possible deposition strategy is to ask the doctor about the causes and/or consequences of the individual's job dissatisfaction. One line of questioning would be to follow out the consequences of that "job dissatisfaction." In many cases you will find that there is evidence that the doctor has actually found data indicating that the job dissatisfaction produced signs and symptoms that could lead an impartial observer to conclude that there was actually a diagnosable clinical depression with perhaps a moderate difficulty in occupational functioning as supported by a history of conflicts with co-workers. Another line of questioning is to inquire about the cause of the "job dissatisfaction," namely some aversive circumstances that could be considered to be industrial events leading to psychopathology. Like "beauty," disorders are sometimes in the eye of the beholder.

With regard to apportionment, the major problem for an applicant attorney is the doctor who has found "too much" apportionment. As we all know, Labor Code section 4663 asks the physician to apportion the amount of permanent disability to the industrial injury and "other factors." Essentially, there is no known scientific method for doing so; I wish there was. This issue comes down to the doctor's judgment. For example, who can say if an awful divorce 20 years ago left the patient vulnerable to developing a clinical depression? The best one can hope to do in this area is to ask the doctor to specify the mechanisms that would have to be operating for that divorce, or any other factor, to have an effect on the applicant's current psychological status.

Cross-Examination From a Defense Attorney's Point of View

From the point of view of a defense attorney the process of developing a strategy to cross-examine a shrink is quite straightforward. First, you determine what the doctor has diagnosed. Second, you look up the specific DSM-IV-TR diagnostic criteria that must be met in order to diagnose the disorder correctly. Third, you see if there are sufficient data in the doctor's report to meet the DSM-IV-TR diagnostic criteria. Simple as pie!

Once you discover that there are no data supporting the doctor's diagnosis, or the data are ambiguous, you develop a set of questions to ask the doctor that, when answered, point out that the doctor did not have sufficient information to diagnose the disorder. After having shown that the doctor does not have the data to support their conclusions it is a short step to showing that the report does not constitute substantial evidence.

For example, let's consider the diagnosis of a Major Depressive Disorder as it is defined in the DSM-IV-TR. As you can see, just like all the other DSM-IV-TR diagnoses, the criteria are very simple, clear and direct. Specifically, the patient must present with at least five of the nine criteria below.

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 while 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 suicidal attempt, or a specific plan for committing suicide.

Then, after first asking yourself, you ask the doctor, "Where in your report of the patient's history and current complaints or, as they are sometimes called, symptoms, are there sufficient patient complaints that meet the diagnostic criteria for a Major Depressive Disorder?"

Next, ""Where in your report of your Mental Status Examination did you discuss the observations that you made that indicate that the patient meets the diagnostic criteria for a Major Depressive Disorder?"

Third, "Where in your report of the psychological testing did you discuss the objective data that indicate that the patient meets the diagnostic criteria for a Major Depressive Disorder?" This one can be tricky since doctors often use tests such as Sentence Completion Tests and/or one or more of the Beck tests, which are either subjectively interpreted, i.e., they have no objective criteria for interpretation, and therefore the doctor can interpret them in any way the want to, or they are inappropriate for use in medical-legal examinations because they do not have the ability to determine the patient's test-taking attitudes or credibility, a major requirement for tests that are going to be used for medical-legal examinations (see my June, 2009 newsletter for a more complete discussion of these tests). Regardless, when tests like these are used the doctor is "free" to say that they show whatever they want to say. However, this is not a dead end for your Cx since you can ask the doctor some very pointed questions about their tests' validity and reliability in a medical-legal context.

Clearly, the most appropriate test to use is one of the three versions of the Minnesota Multiphasic Personality Inventory (MMPI). All three versions of this test generate validity scale scores that indicate the patient's test-taking attitudes and credibility. Moreover, there is a wealth of research data indicating what the scores mean. Some doctors interpret the test scores themselves while others choose to send them out for scoring and interpretation. Unfortunately, some of the interpreting services that use computers to generate interpretations seem not to be reading the psychological testing literature, and they offer interpretations that are not supported by any research. Just where they get their interpretations and why they use them is a major mystery that you can pursue creatively in your spare time.

OK, so now you've got the doctor on the ropes. Here is where you can head in for the "kill." Once you have determined that there are no data in the doctor's report to support their diagnosis, then all of the conclusions that typically flow from a correct diagnosis must fall, like dominoes. Specifically, if the diagnosis is not correct then the conclusion that there has been a psychiatric injury as defined by Labor Code section 3208.2 must fall. Then, since there is no psychiatric injury the question of temporary and permanent psychiatric disability as well as the issue of the need for treatment for that "disorder" is also a moot point. So, clearly the key to almost every cross-examination from the defense's point of view is the doctor's diagnosis or diagnoses.

Another place to question a doctor's report for cases where the injury occurred after January 1, 2005 is the Global Assessment of Functioning (GAF) score. I have discussed the GAF score above, but a little more detail at this point might be relevant. Essentially, a reading of page 34 of the DSM-IV-TR reveals that the GAF score is a number between 0 and 100 that describes the patient's functioning. By virtue of the GAF score being a number it would appear to have some objectivity to it. However, like the comment that Methuselah lived 900 years, this is not necessarily so. Let's see why and then you can figure out how to use this in your Cx's.

There are two legitimate ways for a doctor to arrive at a GAF score. The first is to consider what the DSM-IV-TR calls the patient's "symptoms." However, this is not really what the authors of the DSM-IV-TR had in mind since the word "symptoms" is synonymous with the word "complaints." Obviously, there is more to a psychological examination than simply noting the patient's complaints and no one with any credibility would suggest that only the patient's complaints were relevant in determining a GAF score. Clearly, the doctor has to consider all of the information in the form of as many of the five different sources of information, noted above.

Namely, they also have to consider their Mental Status Examination data, the psychological testing data, the patient's medical records and the collateral sources of information, which are actually rarely available. Once this is done, they come up with a number that describes the patient's clinical presentation. So, during the course of a cross examination it is relevant to ask the doctor, "What specific information in your report led you to conclude that the patient had a GAF score of 50, 60, 70, 80 or whatever?" Hey, that's a fair question and one that the doctor should be able to answer by, at the very least, pointing to patient complaints, Mental Status Examination observations and objective test data to support their conclusion.

The second legitimate way for a doctor to arrive at a GAF score is to consider what the DSM-IV-TR identifies as the patient's ability to function in a variety of areas such as school, work or their social life. Of course, what you are most interested in this area is the ability to function at work. So, during your Cx it is relevant to ask, "What specific information in your report led you to conclude that the patient had sufficient work impairments to support your conclusion that they had a GAF score of 50, 60, 70, 80 or whatever?"

Now, as discussed above, in the area of GAF scores it is important to note that at times the GAF score obtained by looking at the patient's "symptoms" will be different than the GAF score obtained by looking at their school, work or social functioning. However, as also noted above, when there is such a discrepancy, the DSM-IV-TR is very explicit in stating that, and the Schedule for Rating Permanent Disabilities agrees, "It should be noted that in situations where the individual's symptom severity and level of functioning are discordant, the final GAF rating always reflects the worse of the two." Regardless, the doctor has to have data supporting their opinion or they are toast!

Additionally, as noted above, it is possible for an applicant to have more of a psychiatric disability than their GAF and WPI would suggest. Of course, it is also possible that the reverse is true. Thus, it is appropriate to ask the doctor if the patient's occupational functioning is higher than their GAF would suggest! At times the data will lead to an answer that will be "yes" as there are many individuals who have a variety of relatively severe psychological symptoms and comparable GAF scores that can function very nicely at work, thank you.

With regard to apportionment, both the applicant and defense attorney's have the same problem but just in a different "direction." Essentially, the major problem for a defense attorney is the doctor who has found "too little" apportionment. As we all know, and as was noted above, Labor Code section 4663 asks the physician to apportion the amount of permanent disability to the industrial injury and "other factors." Essentially, there is no known scientific method for doing so; I wish there was. This issue comes down to the doctor's judgment especially since recent research has clearly demonstrated that aversive past experiences can have a hardening effect that will make the individual more resistant to subsequent stressors (Seery, M.D., Holman, E. A. and Silver, R.C. Whatever does not kill us: Cumulative Lifetime Adversity, Vulnerability, and Resilience. Journal of Personality and Social Psychology. 2010, 99,1-17). For example, who can say if an awful divorce 20 years ago left the patient with less vulnerability to developing a clinical depression? The best one can hope to do in this area is to ask the doctor to specify the mechanisms that would have to be operating for that divorce, or any other factor, to have an effect on the applicant's current psychological status.

FINAL CONCLUSION

Of course, there are many other places to approach an AME or a PQME's report, many of them not so pleasant and "friendly," but those discussed above are the "biggies." Essentially, if you aim your questions at the doctor's DSM-IV-TR diagnoses and their GAF score, pointedly asking about the location of the data in their report that supports those conclusions; you will often find only hot air. Similarly, another approach is to show that the doctor has overlooked or not collected enough information, or has misinterpreted the data they have collected. For me, the bottom line, after doing this work for most of my adult life, is that an overwhelming majority of psychological and psychiatric reports can be successfully attacked.

This is the twenty-sixth 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.