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

April, 2011
Volume 1, Issue 27

The Mental Status Examination-Revisited

For those of you who have been getting and following my monthly newsletters you may recall that in August, 2010 the subject of my newsletter was the Mental Status Examination. In that newsletter I outlined what should be contained in the doctor's report of a Mental Status Examination. I also described the basic methods that should be used to obtain those data. Both before and since that time I have written a number of newsletters that address the issues of flaws that can be found in psychological and psychiatric reports. In fact, as you may recall, last month I devoted the entire newsletter to discussing how to cross-examine an AME or a PQME who has written a flawed report.

This month's newsletter is dedicated to finding substantial flaws in Mental Status Examinations. While most attorneys, judges and insurance adjusters have read the *Mental Status Examination* sections of psychological and psychiatric reports, how many actually know when those examinations fall short of the goal and reveal flaws that question the credibility of the doctor's conclusions? Well here's the skinny!

A Brief Review of the Basic Nature of a Mental Status Examination

As discussed in my August, 2010 newsletter, a Mental Status Examination is part of the doctor's face-to-face interview of the patient. It produces a set of observations of the patient that are made by the doctor under reasonably controlled conditions employing a relatively standard set of examining techniques and questions. By using these techniques and asking the appropriate questions the doctor makes observations that enable him or her to provide the reader with information about the patient in eight basic areas: orientation and appearance, general behavior, mood, memory, attention, major psychological disorders, functional abilities and social behavior. Check out the August, 2010 newsletter for a complete discussion of the various methods used in collecting Mental Status Examination data.

Email us:
DrLeckartWETC@gmail.com

Have any questions about this newsletter or psychology in general, call (310) 444-3154.
No written report, no fee!

"While most attorneys, judges and insurance adjusters have read the Mental Status Examination sections of psychological and psychiatric reports, how many actually know when those examinations fall short of the goal and reveal flaws that question the credibility of the doctor's conclusions?"

Six Frequently Found Problems in Mental Status Examinations

After reading and critiquing psychological and psychiatric medical-legal reports for more than 25 years I have learned that there are a variety of ways that doctors can make errors when it comes to conducting and reporting on a Mental Status Examination. Recognizing these problems is essential to cross-examining doctors during depositions and courtroom testimony and therefore the outcome of litigation. Presented below are six of the major flaws or problems I've seen over the years.

Flaw #1 Inconsistencies Between the Doctor's Diagnosis and their Mental Status Examination Data

As noted earlier, 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. If a reading of the doctor's report does not reveal that they made observations consistent with their diagnosis, then their report is not credible. For example, in the cases of a Major Depressive Disorder, individuals who are clinically depressed may present with at least some 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. 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 and narrative themes can be observed in the context of a Mental Status Examination. Of course, if there are insufficient observational data in the doctor's report to support the

diagnosis of a Major Depressive Disorder, the doctor's report is not credible. One of my "favorite errors" is the doctor who has diagnosed a Major Depressive Disorder but reports the patient's mood as "euthymic." One does not have to be the sharpest knife in the draw to know that "euthymia" is defined as a normal mood and that a Major Depressive Disorder is a Mood Disorder.

Flaw #2 Incomplete Mental Status Examinations

On many occasions I have reviewed reports that contain what purport to be Mental Status Examinations that fall far short of providing data consistent with standards in the psychological and psychiatric community for such examinations. In many of these cases the doctor has simply summarily stated that the patient appeared depressed. However, no observational data were offered regarding that conclusion. Of course, this leaves both the reader of the report and the court wondering what the doctor observed that led them to conclude that the patient was depressed. Similar errors occur in other areas. For example, it is not unusual to find that a doctor has stated that "the patient's short-term, intermediate and remote memory were impaired." However, when there are no data supporting that conclusion, this is a major flaw in the doctor's report. This is especially relevant since it is normal procedure to test a patient's memory during the course of a Mental Status Examination with a battery of objective techniques that yield easily reported upon observational data. Regardless, whether the doctor gave those tests and never reported the data, or simply summarily concluded that the patient's memory was impaired, is really not the issue. The crucial issue is that the doctor did not provide support for their conclusion, leaving everyone to wonder what really was observed and what is true about the patient. Similar examples of incomplete Mental Status Examinations abound, but I think I've made my point, which is that Mental Status Examinations that are written without supporting data are substantially flawed and hurt everyone involved.

Flaw #3 Inconsistencies Between the Patient's Complaints and the Doctor's Observations

Two sets of data that are found in every psychological report are the doctor's report of the patient's complaints or symptoms and the doctor's report of their Mental Status Examination findings. Unfortunately, at times these two sets of data are not highly and positively correlated. For a variety of reasons the patient may complain of one thing and the doctor may report they have observed another. For example, the doctor may state that the patient complained of suicidal thoughts during the history taking, but in reporting on the Mental Status Examination the doctor may explicitly mention that they observed no such narrative statements made by the patient. Most embarrassingly for the doctor, I have seen reports where the doctor does not even recognize this inconsistency. In these cases, the doctor may report complaints of suicidal thoughts but state they observed no such narrative statements, never mentions the discrepancy between the complaints and their observations, and makes no attempt to explain the data. This is not good!

There are many other ways in which inconsistencies can find their way into medical-legal reports. For example, during his or her report of the patient's history the doctor may state that the patient complained about their memory but in discussing the results of the Mental Status Examination the doctor may present data or provide a summary conclusion indicating they observed no defects in memory. Similarly, during the Mental Status Examination the patient may appear to be quite angry, but when discussing the person's history the doctor describes no such symptom or complaint. While it is always interesting to speculate about the reason for these inconsistencies, it is a wise evaluator who notices these discrepancies and either resolves them during the clinical interview, by asking the patient some appropriate questions, or who explains any unresolved inconsistencies in their report.

If inconsistencies between a doctor's Mental Status Examination observations and the patient's complaints are not resolved, the doctor can once again imagine being cross-examined by an attorney who asks, "Dr. Jones, I see here on page 12 of your report that you stated that during your Mental Status Examination you observed that Mr. Brown was depressed, but where you discuss your conclusions on page 26 you made no mention of Mr. Brown complaining about depression. How can you explain this inconsistency?"

Flaw #4 The Use of a Folstein Mini Mental Status Examination

On occasions you will see reports where the doctor will report on the result of a Folstein Mini Mental Status Examination. It is important not to confuse this examination with a complete Mental Status Examination. In this regard, the Folstein Mini Mental Status Examination is limited to 11 questions that were devised for use in testing the cognitive states of hospitalized geriatric and general psychiatric patients

(Folstein, M. F., Folstein, S. E. & McHugh, P. R. Mini-Mental State: A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research, 1975, 12, 189-198). Clearly, the Folstein Mini Mental Status Examination can only provide information about the patient's orientation, memory, language ability and level of alertness. Unlike the more complete Mental Status Examination, it provides no information about the patient's mood, social behavior or serious abnormal mental experiences. In short, since the Folstein Mini-Mental Status Examination is without the depth or breadth of a normal Mental Status Examination, the use of this "instrument" in medical-legal evaluations is extraordinarily limited.

Flaw #5 The Mental Status Examination Checklist

Finally, on occasions you may come across a doctor who has used a Mental Status Checklist for Adults. A reading of the psychological literature indicates that the marketers of this "test," Psychological Publications, Incorporated, reveals that the Mental Status Checklist for Adults is a checklist of 120 items that reportedly was written by Dr. John A. Schinka, a neuropsychologist at the Florida Alzheimer's Disease Research Center**.** The marketers go on to report that this instrument explores content that is usually covered during the administration of a face-to-face clinical interview. However, while the name of the instrument would appear to indicate that the test deals with the Mental Status of an adult, the marketer's description of the checklist indicates that it also covers the test-taker's presenting problems, symptoms or, as they are sometimes called, complaints and surveys the test-taker's health and habits, legal issues, their current living situation and what the marketers call the individual's "current living situation, diagnoses, treatment recommendations, and disposition" (http://www.hogrefe.co.uk/?/test/show/225/). In a more detailed advertisement for the "test" the marketers state that it covers the individual's presenting problems, legal issues, current living situation, diagnoses, treatment recommendations, and health and habits, none of which are considered to be part of a traditional Mental Status Examination found in medical-legal reports (http://www.tjta.com/products/TST_045.htm). All of the above are not areas that are explored during a conventional Mental Status Examination but are concerned with data that are usually obtained during the taking of a patient's history. As such, the expressed purpose of this "test" is not limited to investigating an adult's Mental Status, but is designed to obtain historical data. Accordingly, the use of this instrument as a substitute for a traditional face-to-face Mental Status Examination is not appropriate.

Flaw #6 Summary Conclusions

From my point of view, the worst errors found in medical reports are summary conclusions. In this regard, it is not unusual to find that a doctor has reported in their Mental Status Examination, "the patient's mood was depressed." When such a summary conclusion is presented without any data I think everyone would agree that the doctor is skating on the thinnest of ice. Obviously, all involved parties to the claim would want to know, and have a right to ask about exactly what the doctor observed that led them to that conclusion. Similarly, doctors sometimes summarily state, "the patient's memory was defective." OK, if that is true, what data did the doctor obtain that supports that conclusion? Summary conclusions or conclusions without supporting data, are obvious and substantial flaws in a doctor's report that seriously question all of the other conclusions in the doctor's report including those of whether or not the patient has a DSM-IV-TR psychological disorder and has suffered a psychiatric injury.

In Summary

Overall, a Mental Status Examination provides one set of data concerning the patient that must be integrated with the other information available to the doctor in coming up with a highly internally consistent picture of the examinee. In this regard, the Mental Status Examination provides a set of doctor-made observations of the patient collected under reasonably controlled conditions employing a relatively standard set of examining techniques and questions. If those data do not "fit" with the doctor's conclusions, "something is rotten in Denmark."

This is the twenty-seventh 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.