THE WETC PSYCHOLOGY NEWSLETTER

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The Credibility of Psychological Diagnoses

The most crucial part of any psychological report in the medical-legal arena is the doctor's diagnoses. Whether the case is in workers' compensation or personal injury all of the conclusions found in the doctor's report depend on their diagnoses. If those diagnoses are not supported by the doctor's data then all of the doctor's conclusions concerning the existence of a psychiatric injury, a psychiatric disability and the need for psychological and/or psychiatric care are also unsupported.

In order for any diagnosis to be correct, it must conform to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). That is, there must be data in the doctor's report indicating that the patient has met the criteria for the disorder that was diagnosed. If the patient does not meet those criteria it is not reasonable to conclude they have the disorder and, as mentioned above, if they do not have the disorder then any conclusions about a psychiatric injury, a psychiatric disability or a need for mental health treatment are unwarranted.

Having said the above, it is important to understand how a doctor goes about making a diagnosis. The answer to that question is very simple. Psychological diagnoses are made after considering as many as five different sources of information: (1) the patient's life history and their presenting complaints or, as they are sometimes called, symptoms; (2) the doctor's report of their Mental Status Examination findings; (3) the results of an objective psychological test battery; (4) the data found in the patient's medical records and, (5) any collateral sources of information that might exist.

(1) the patient's life history and their presenting complaints or symptoms

In order for a psychological diagnosis to be correct there must be sufficient complaints or symptoms to warrant the specification of that disorder. For example, a Major

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"in order to write a decent psychological report, or evaluate the credibility of any such report, the doctor uses at least the patient's history, their own face-to-face Mental Status Examination observations and the objective psychological test data."

Depressive Disorder is one of the most frequently diagnosed disorders found in litigation. According to the DSM-IV-TR, in order to diagnose any form of a Major Depressive Disorder correctly the person must present with symptom #1 and/or symptom #2 and a total of at least five of the following nine symptoms given 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.

More specifically, the patient must provide a history of having these complaints and the doctor must discuss that history in their report. Clearly, the doctor cannot simply summarily state that the patient "complained of a depressed mood," but they must provide a discussion of the qualitative nature of those complaints. Probably the best way of doing this is to quote the patient's actual statements such as:

> "I wake up and I see no future in my life. I feel that it is the end of the world. Sometimes I just lock myself in my room and cry. I don't feel like I want to do anything. I am not able to sleep. Sometimes I feel like killing myself. I feel as if I'm not worth anything. Life doesn't really matter."

Another way is for the doctor to provide the statements or complaints made by the patient in something less than a direct set of quotes. For example, the doctor can say that the patient reported that they have trouble falling asleep, that they feel like killing themselves, that they no longer like themselves, or that they cry a lot for no reason at all.

However, it is simply not enough to provide a listing of the patient's complaints or their direct statements. Specifically, the doctor has to describe the frequency, intensity, duration, onset and course of those complaints. Think of this as a series of questions that have to be answered: How often do you feel/think that way? (frequency). How severe is this problem for you on a 10-point scale? (intensity). When you feel depressed, how long does the feeling last? (duration). When did you start feeling depressed? (onset). Has your depression been getting better or worse and can you describe its presence over time? (course). The provision of this information, in the case of a Major Depressive Disorder, especially the data about frequency, is quite crucial since eight of the nine complaints must be found to be present at least "nearly every day."

Overall, if the doctor has not provided a sufficient number of complaints to indicate that the patient has the disorder they diagnosed, that diagnosis is unsupported and the doctor's report is substantially flawed.

(2) the doctor's report of their Mental Status Examination findings

The second set of data found in virtually every report is the doctor's Mental Status Examination findings. In this regard, a Mental Status Examination produces a set of observations of the patient that are made by the doctor, during their face-to-face meeting, using a relatively standard set of examining techniques and questions that yield easily reported upon objective data. Those doctor-made observations are called "signs," and should not be confused with the patient-made complaints, since they are often different. The nature of the techniques used by doctors is most easily understood in talking about the patient's memory, concentration and judgment. These processes are easily measured during the course of a Mental Status Examination with such techniques as asking the patient to recall a series of numbers, asking them to count backward by 7's or asking them to provide interpretations of proverbs or to describe in what way an elephant is similar to a whale. Sticking with the diagnosis of a Major Depressive Disorder, individuals who are clinically depressed will often have signs, or observable behaviors, of dysfunctions in these areas.

In addition to these objective techniques, individuals who are clinically depressed may present with themes in their narrative of worthlessness, hopelessness, helplessness, incompetence, self-reproach, guilt, pessimism, failure, difficulty thinking, difficulty making decisions, a loss of interest in pleasure, demoralization and thoughts of death and/or suicide. Behaviorally, in addition to the techniques used to observe reduced cognitive functioning, the clinically depressed patient may present with signs of psychomotor retardation or agitation, looking as if they are about to cry, attention deficits, sadness or flat emotional expression, tearfulness, irritability, indecisiveness and/or social withdrawal.

If the doctor has not demonstrated in their report of their Mental Status Examination that they have observed a clinical depression, they have not presented evidence demonstrating that the patient is depressed and their diagnosis of any form of a Depressive Disorder is simply not credible.

In passing, it should be noted that it could be very unlikely to observe signs of some of the disorders found in the DSM-IV-TR during the doctor's Mental Status Examination. For example, Panic Disorders, which are characterized by Panic Attacks, typically occur relatively infrequently and therefore would probably not be observed during the course of a face-to-face clinical interview. In next month's newsletter I'll talk about both.

3) the results of an objective psychological test battery

The third source of data that can support a doctor's psychological diagnosis is the objective psychological testing battery. Unfortunately many of the tests used by both psychologists and psychiatrists are not capable of providing meaningful information. Essentially, to be useful in providing information about a patient's psychological status the first question that a test must

answer is, "Did the person complete the test in an honest and straightforward manner?" As such, the gold standard in psychological testing is the Minnesota Multiphasic Personality Inventory (MMPI). It has been around since the early 1940's and has been the subject of thousands of peer-reviewed journal articles. It has a variety of validity scales for determining the patient's test-taking attitudes and credibility. Interpreting the MMPI is a two-stage process. The first stage involves examining the validity scales, which typically provide objective information about the patient's credibility and approach to testing. If the person has not taken the test in an honest and straightforward manner, nothing further can be said about their scores on the MMPI. However, if they were honest and straightforward the scores on the clinical scales can be interpreted to provide information about the patient's psychological status, including the possible existence of psychopathology. In this regard, there are numerous books and journal articles in the literature that provide a summary of the research demonstrating what any given set of scores means about the person's psychological status.

Having covered the basics of the MMPI it is important to mention that additional tests may be indicated or helpful in an evaluation, depending on a patient's particular presentation and the specifics of the case. However, there are many tests available, most of which require substantial training and experience in administering and interpreting. Many of the tests being used in medical-legal examinations are completely incapable of providing meaningful information about a person's psychological status. For example, symptom checklists and some brief inventories provide the patient with a set of symptoms or complaints that they can endorse or deny. However, there are no standards for interpreting the results of these tests nor is it even reasonable to give such a test in a medical-legal context since the presentation of the list of complaints found on the checklist can be an encouragement to claim symptoms that do not exist.

Similarly, projective tests like the various sentence completion tests are similarly positioned. A sentence completion test gives the person the first part of a sentence that they can complete in any way they want. The assumption of these tests is that the way the patient completes the sentences is revealing about their psychological status. For example, one such sentence stem offered for completion might be, "I often feel……." Such open-ended measures are generally used in clinical settings for supplementary purposes along with other, more objectively-based tests or evaluative strategies. Unfortunately, there are no widely-accepted standards for interpreting the patient's productions on these projective measures, and no way of determining if the patient is giving the doctor an honest account or is trying to look better or worse than they actually are.

Lastly, among all the tests I'll talk about are questionnaires which are often in the form of multiple choice items that appear to ask reasonable questions and have been shown by some amount of research to provide information about people. However, some of these instruments are not designed to detect psychopathology and a reading of the testing manuals for these tests indicates that the authors of the instruments directly state that the tests are inappropriate for diagnostic purposes. Unfortunately, you have to have access to either the testing manuals or at least to a qualified professional to know which tests are like this.

At times the psychological testing results can lead to well-reasoned but misleading interpretations. However, direct observation in the form of the doctor's description of the patient's symptoms or their own observations of the patient's signs do not have this problem unless the doctor is outright lying, or lazy in collecting thorough data.

(4) the data found in the patient's medical records

The fourth set of data used to arrive at diagnoses are the patient's medical records. Here the doctor conducting the evaluation may use available mental health records that provide some insight into the patient's psychological make-up by discussing what those records reveal. Unfortunately, many psychological reports, especially those authored by doctors in the context of a medical-legal evaluation, are flawed. Additionally, records made by mental health professionals who may have had contact with the patient outside of a medical-legal context typically do not completely document their findings and observations. In these cases many of the records are sketchy at best, often providing just summary conclusions and "naked" diagnoses without empirical support.

Further, many physicians in a wide variety of medical specialties often make comments in their records indicating that the patient may be depressed, anxious or having other psychological problems or disorders. However, with all due respect to my

colleagues in the various fields, a psychological diagnosis offered by, let's say, an orthopedist is likely no more credible than would be my diagnosis of an orthopedic condition, which I can comfortably assert is not in the least bit credible.

(5) any collateral sources of information that might exist

Finally, doctors sometimes rely on collateral sources of information. There are times when it is not possible to obtain useful information from a patient who has filed a claim of a psychiatric injury. Consider the obvious case where the patient has passed away and their claim has not resolved. At those times a psychologist may be called upon to conduct a psychological autopsy, or to provide an opinion of the patient's psychological status before they died, including some conclusions about the cause of any possible disorders. In these cases, talking to relatives, friends and co-workers is a valuable source of data in addition to reviewing the patient's medical records.

Similarly, there are times when a living individual is incapable of providing information either because of their physical health or perhaps because they are suffering from some form of developmental disorder. Think about a person with a very low I.Q. who has been injured but may be completely incapable of providing a narrative concerning their feelings, thought and behaviors. What's a doctor to do? Talk to their relatives, friends and/or co-workers. While it might not provide perfect answers to the pertinent questions, it's the best information in town.

In summary, in order to write a decent psychological report, or evaluate the credibility of any such report, the doctor uses at least the patient's history, their own face-to-face Mental Status Examination observations and the objective psychological test data. These sources of information are often supported by the patient's medical records and/or sometimes by collateral sources of information although the latter are relatively rarely used in medical-legal cases. Regardless, if the doctor does not have sufficient hard data to support their diagnoses then it is reasonable to conclude that their report is substantially flawed, grossly lacking in credibility and not capable of supporting any conclusions about a psychiatric injury, a psychiatric disability or a need for psychological or psychiatric care. Under these circumstances it is also reasonable to conclude that the doctor's report has violated community standards in psychology and psychiatry for the examination of patients and the preparation of reports for the courts.

This is the twenty-ninth 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.