THE WETC PSYCHOLOGY NEWSLETTER

Dr. Bruce Leckart

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

April, 2012
Volume 1, Issue 39

Depositions are War! How to Win!

Once upon a time, actually before January 1, 2005, life for workers' compensation attorneys and adjusters was simple. If you were on the defense side, you got a doctor; the doctor wrote a report. If you were on the applicant side, you got a doctor; the doctor wrote a report. Of course, the doctors disagreed with one another. No big problem. When it came time to determining which doctor was "right," you had your doctor write an opinion about the other side's report and the other side did the same thing. After a bunch of supplemental reports, things sorted themselves out. No big deal. The doctors, the attorneys and the court worked it out.

Now comes the 2004 law. No more dueling doctors. Now there is just one AME or one PQME. Unfortunately, that's often a problem. Let's say one of the attorneys doesn't agree with what the doctor has said. Disagreements of this type are likely to occur since it is rumored that a lot of PQMEs are doctors who work out of hourly offices in a multitude of zip codes and may not care about what's in their reports since they are not likely to get a lot of repeat referrals. Similarly, it is rumored that some AMEs have their favorite defense and/or applicant attorneys and may be "shading" their reports to benefit their favorites. Now, only a dunderhead thinks that attorneys are dunderheads. They know when they've been "had" by a doctor's report. This can be especially meaningful when you have a million dollar case at stake. Sounds like an important deposition coming up!

The bad news is that depositions are not fair fights. Let's just talk about psych cases. On the one hand you have the doctor who has either an M.D. degree with postdoctoral training in psychiatry or a psychologist with a Ph.D. or Psy.D. degree. On the other hand you have the attorney who has scheduled a deposition who, with no disrespect to any reader, may have had a few courses in psychology as an undergraduate a decade or more ago. Now how can the attorney win that battle? It's David against Goliath and David left his slingshot at home. An attorney has about as much chance of winning such a fight as I would have going into court and arguing about the rules of evidence, namely zero!

"Who do you call for help? The answer is not Ghostbusters but an experienced psychologist or psychiatrist who can read the offending and probably incorrect and misleading psych report and write a pre-deposition consultation report, or simply have a telephone conversation or an in-person meeting with the attorney who wants the deposition, explaining to them at length all the flaws that he or she can find in the doctor's report."

Who do you call for help? The answer is not Ghostbusters but an experienced psychologist or psychiatrist who can read the offending and probably incorrect and misleading psych report and write a pre-deposition consultation report, or simply have a telephone conversation or an in-person meeting with the attorney who wants the deposition, explaining to them at length all the flaws that he or she can find in the doctor's report. Once having done that, they can feed the attorney with questions that are designed to point up those flaws and either get the doctor to change their "biased" opinions or go to court and get the report thrown out as not being substantial evidence. Case closed.

In order to understand what you should be getting in a pre-deposition consult it is necessary to understand the construction of a psychological report and how the conclusions are, or should be, arrived at.

Psychological reports are based on as many as five sets of data. Those five sets of data are:

1. The patient's life history and their presenting complaints.

2. The doctor's report of their face-to-face observations of the patient during the Mental Status Examination.

3. The objective psychological testing data.

4. The doctor's review of the patient's medical records.

5. Any collateral sources of information available to the doctor in the form of interviews of the patient's friends, relatives and/or co-workers. This information is almost never present in a workers' compensation case.

All of the data that are present must be used by the doctor to arrive at a DSM-IV-TR psychological diagnosis. That diagnosis is the keystone of every report. Unless the diagnosis is dead on correct, the doctor's report is in trouble. The reason for this is simple, all of the conclusions relevant to the court are based on the doctor's diagnosis. The doctor's diagnosis is typically the weakest point in a psych report. If you are trying to change a doctor's opinion, it is best not to approach the GAF score, causality, apportionment or the need for treatment. To continue with the war analogy, the weakest point is the diagnosis and that is where you must attack. Just for the record, if you try to attack the other conclusions the doctor can usually end the questioning by simply stating, "in my professional opinion……." This is not true about their diagnosis, which must conform to the DSM-IV-TR diagnostic criteria.

Let's look at it from a defense attorney's point of view. If the doctor arrives at a DSM-IV-TR diagnosis and the doctor's diagnosis is not correct, or not supported by the data in their report, then any conclusions drawn about whether or not the person has had a psychiatric injury as defined by Labor Code section 3208.3 are simply not sustainable. Once there is no injury there can be no temporary or permanent psychiatric disability and no need for treatment. Case closed.

Similarly, from the applicant attorney's point of view let's say the doctor has taken a history, given a Mental Status Examination, administered some psychological tests, read the medical records and concluded that there is no DSM-IV-TR disorder and no psychiatric injury. This is, of course, the infamous "washout" report. However, unless that doctor has presented evidence demonstrating that they have taken a complete history, used the appropriate Mental Status Examination techniques and presented all of the data, given clinically valid and reliable tests such as the MMPI and presented the data, and read and discussed the credibility of any medical records their conclusions are not reasonable.

For heuristic purposes, let's be a bit extreme or bizarre about "washout" reports. Imagine for a moment that the AME or PQME has simply asked the applicant how they are and accepted an answer such as "I'm OK" and observed how the patient was dressed, as well as how they walked and talked. With a really "thin" examination like this the doctor could conceivable come up with a diagnosis of "No Disorder. Simply by not asking the appropriate questions or using the correct measurement techniques it is possible to find nothing! Now, how many attorneys will know what are the right questions to ask, what Mental Status Examination techniques are needed, what the testing scores mean or how to interpret comments in the medical records? If you said "almost none," you'd be correct.

Equally unnerving to an applicant attorney is the doctor who diagnoses the correct disorder and then decides that all, or almost all, of the cause of the disorder and/or the permanent disability is due to non-industrial events but never provides any logic or a reasonable connection between those non-industrial events or any other strong reason for arriving at that conclusion except their "professional opinion". How do you deal with that? For example, what questions do you ask to demonstrate that there is no connection between their conclusion that there is a disorder and a GAF score of 72? It's a tough problem, but there are solutions.

I suspect that not one attorney in 100 can effectively deal with either of the above. Support for this conclusion comes anecdotally from a talk I recently gave to a Bar Association meeting where I asked for a show of hands and only one attorney out of about 60 said that they had ever gotten a psychologist or a psychiatrist to change an opinion during a deposition.

Let's go back to the applicant attorney's position. Another way of washing out an applicant is to say that the only thing that they have wrong with them is a Personality Disorder. This can result in a credible "washout" since Personality Disorders are lifelong patterns that become evident no later than late childhood, adolescence or early adulthood. They present as an enduring pattern of inflexible and pervasive behaviors that occurs across a broad range of personal and social situations and lead to clinically significant distress or impairment in social, occupational or other important areas of functioning. Personality Disorders can be aggravated by industrial events but one can also effectively argue that the Personality Disorder has not been aggravated but exacerbated by non-industrial events or itself was the cause of major problems in the workplace.

In such a case it may be effective to demonstrate that the applicant has no such Personality Disorder. In this case, your best friend is the DSM-IV-TR. Every attorney and adjuster who ever expects to have another psych case should have one of these books on their desk. I've seen new paperback versions advertised on the Internet for as little as $23.90, with shipping. The great thing about the DSM-IV-TR is that it defines all the criteria needed to arrive at the hundreds of different psychological diagnoses in easy to understand English. One does not have to be a rocket scientist or a Ph.D. or M.D. to get a copy of the diagnostic criteria for any of the eleven Personality Disorders, or any other disorder, and sit down with those criteria and the doctor's report and see if the two sets of information correspond. Do the contents of the doctor's report conform to the DSM-IV-TR diagnostic criteria? If not, there's trouble in River City!

Another source of information is my website, www.drleckartwetc.com where you can find a variety of helpful information. For example, you can find the 2011 version of my book Psychological Evaluations in Litigation: A Practical Guide for Attorney and Insurance Adjusters. It's posted and you can use if for free. Take as much time as you want browsing and pulling out information. Among other things it has a complete and easy to understand description of the DSM-IV-TR diagnostic criteria for the most frequently found disorders in workers' compensation and personal injury litigation such as a Posttraumatic Stress Disorder and a Major Depressive Disorder. You'll also find descriptions and critiques of almost all the psychological tests used in litigation, a detailed description of what should be in a doctor's report of a Mental Status Examination and a glossary. In addition, I've recently added a more extensive glossary of psychological terms on the website in case you run into a psych report that uses a bit too much psychobabble. Also on my website are, at last count, 39 monthly newsletters. One of my favorites is from May, 2010. It's all about "Impossible" MMPI-2 scores. In this regard, the MMPI-2 has 13 basic scales and not every MMPI-2 score can possibly be obtained on each of those scales. A simple table will allow you to single handedly determined if the report you are reading contains scores that could not possibly have been obtained by the applicant. I'm betting you can figure out how to use that piece of information. Finally, I invite all of you to give me a call and send me a report for a free telephone consultation. If I am not asked to write a report you won't get a bill!

This is the thirty-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 listed on the next page, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.

February, 2009 – Litigation Problems With The GAF

March, 2009 – Common Flaws In Psych Reports

April, 2009 – The Minnesota Multiphasic Personality Inventory (MMPI)

May, 2009 – Apportioning Psychiatric Disability In Workers' Compensation cases And Assessing Aggravation In Personal Injury Cases

June, 2009 - Subjectively Interpreted Projective Psychological Tests

July, 2009 - Sleep Disorders And Psychiatric Injuries

August, 2009 - Posttraumatic Stress Disorder

September, 2009 - Compulsive Computer Use Disorder

October, 2009 - Major Depressive Disorder

November, 2009 - The Millon Tests

December, 2009 - Psychological Factors Affecting Medical Condition

January, 2010 - Pain Disorders

February, 2010 - Common flaws in psych reports #2

March, 2010 - Drugs: Use, Abuse and Dependence

April, 2010 - Common Flaws In Psych Reports #3

May, 2010 - "Impossible" MMPI-2 scores and their consequences for litigation

June, 2010 - Adjustment Disorders

July, 2010 - Bipolar Disorders

August, 2010 - Mental Status Examination

September, 2010 - Symptoms, Signs and the GAF: A Potential Litigation Problem

October, 2010 - What vs. Why: Determining Causality in Psych Cases

November, 2010 - Tightrope Walking and the GAF

December, 2010 - Apportioning Psychiatric Injuries: A More Complete View

January, 2011 - Personality Disorders

February, 2011 - Apportioning Psychiatric Disability With Multiple Orthopedic Injuries

March, 2011 - How To Cx a Shrink

April, 2011 - The Mental Status Examination - Revisited

May, 2011 - Dysthymic Disorder

June, 2011 - The Credibility of Psychological Diagnoses

July, 2011 – Physical and Psychiatric Injuries: A Tale of Three Patients

August, 2011 – Panic Attacks and Panic Disorders

September, 2011 – Psychological Treatment Records

October, 2011 – Anger: An Overlooked Injury

November, 2011 – Neuropsychology and Psychiatric Injuries

December, 2011 – GAF: What Every Litigator Needs to Know

January, 2012 – Violence in the Workplace

February, 2012 – Malingering (V65.2)

March, 2012 – Apportionment of Orthopedically Produced Permanent Psychiatric Disability: Food For Thought