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Foreword

This book is being written as a reference for attorneys and insurance adjusters. It is being written to help them evaluate the credibility of specific psychological and psychiatric reports and to make decisions about which doctors to hire. It is also being written to help them take more effective courtroom and deposition testimony from patients who are claiming psychological injuries and from doctors who are testifying as expert witnesses. If I achieve my goal, attorneys and insurance adjusters will be able to use this work to negotiate more just and favorable settlements of psychological claims and litigation.

This is a book about adults who have filed litigation or a formal claim of a psychological injury with an insurance carrier or a private person. It is based on my 43 years of experience in psychology since receiving my Ph.D. at Michigan State University in 1965. It is also based on 30 years of teaching psychology at the university level and 32 years of private practice as a psychologist in Southern California. For more than two decades I have been working in the medical-legal area or what is sometimes called forensic psychology, which is the branch of psychology that deals with legal issues. Forensic psychologists provide services that often include writing reports of their examinations or evaluations and providing courtroom testimony in criminal cases, child custody hearings, involuntary hospitalizations, personal injury cases and work-related injuries. My specialty has been in personal injury and work-related injuries in adults.

In the coming pages I will provide you with information that I have gleaned from my 23 years of experience working as the owner and president of the Westwood Evaluation & Treatment Center. During that time I have participated in the evaluation and/or treatment of thousands of people who have been referred for psychological evaluation and/or treatment as a result of a psychological injury. Some of the people I have evaluated were referred to me by their attorneys, while others were sent by an insurance company or a defense lawyer. Still others were sent to me by both parties who agreed to use me as the sole or agreed medical evaluator. Most of my recent referrals have come from the defense in conjunction with workers’ compensation claims. However, the information,
procedures, and principles of psychological evaluations and expert testimony discussed in this book are the same regardless of which “side” refers the case.

Some people in the medical-legal community refer to doctors working as expert witnesses as “hired guns,” authorities expected to provide a report that will make the referral source happy by writing what the source wants to hear. However, it has always been my belief that doing so results in a short career, since besides one’s knowledge and skill, the doctor’s reputation is really the only thing he or she has that is valuable. Essentially, when that reputation is marred, by acting as a hired gun and producing opinions that cannot be supported by hard cold data, one’s practice disappears. In this regard, I have adopted an attitude of “I’ll call it the way I see it and let the chips fall where they may.” It seems to have worked for me for what I think is one good reason. I never ever say anything that I have not backed up with a considerable amount of factual data. Overall, with respect to making my referral sources happy, my attitude from Day One has been, “If I’ve drawn a conclusion that is not good for your side, unless I’ve made an error, there’s nothing I have to apologize for.” On balance, what I think has made my practice successful, and what I am most proud of, is that I’ve tried to produce the most thorough and detailed report possible that is based on thorough and detailed data that will stand up to the highest levels of scrutiny. I also believe that in getting to that place I have had a substantial advantage as a result of coming from an academic background, which is fundamentally very scientific and precise in data collection, analysis and interpretation. Thus, while I am aware that it may be somewhat arrogant to say so, “If you can find the holes in my work……..bring it on!”

Overall, the major message of this book is that while the level of services provided by many psychologists, as well as related mental health professionals such as psychiatrists, meets or exceeds the standards in the community, there are many occasions when those standards are not met. In fact, while it is not my intent to insult my colleagues, I believe that the quality of reporting in forensic cases in workers’ compensation and personal injury is often quite poor. I think you can get an idea of just how poor it is by reading Chapter 9, where I discuss the major flaws to be found in psychological and psychiatric
reports. While my short-term goal is to help attorneys and adjusters arrive at more just outcomes and win more cases, hopefully, if I do my job properly, the information in this book will also be used by judges, psychologists, psychiatrists and other mental health professional to elevate the standards in my profession. If I can do that, my time will have been well spent.

Lastly, I would like to note that throughout almost the entire time I have worked in this field I have been assisted by a staff of exceptionally talented psychologists and psychiatrists, as well as ancillary office personnel. While I take full responsibility for the contents of this book, it is this staff, as well as the many patients I have examined and treated, that have taught me the lessons that I am now trying to share.
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achieved only through my own persistently hardheaded unwillingness to listen to reason.
About the Author

Bruce Leckart is a product of the public schools of the Bronx, New York, where he graduated from William Howard Taft High School in 1956. After brief and unsuccessful stints at Pratt Institute, Hunter College and the City College of New York he found his way to Michigan State University where he trained in psychology, receiving a Ph.D. in 1965. He subsequently was an assistant professor at Ohio University between 1965 and 1968 at which time he relocated to San Diego, California and began teaching at San Diego State University. He became a full professor at that institution in 1971 and retired from the university in 1994. While maintaining a full time faculty position, he started a private practice in 1976 and was one of the founders of the assertiveness training movement. He began a private practice in forensic psychology in 1985 that ultimately became the Westwood Evaluation & Treatment Center with multiple offices in Southern California. During his career he has published about 30 articles in professional journals in addition to presenting many papers at professional meetings, contributing to the best seller, *When I Say No, I Feel Guilty* and writing *Up From Boredom, Down From Fear*. He is currently a Qualified Medical Evaluator in California and continues to work as a consultant and to conduct forensic psychological evaluations in personal injury and workers’ compensation.
Disclaimer

All of the names used in this book are purely fictional. The only exceptions are my own and the names of the professionals cited in the references. While the description of my experiences in conducting evaluations and teaching are true, substantial elements of those few stories that I have presented have been changed to make it impossible to identify any of the participants. Most importantly, the reader of this book should keep in mind I am not an attorney and have had no legal training. Accordingly, nothing in this volume should be construed as providing any legal advice to anyone. If you think you may be in need of legal assistance, I recommend you contact an attorney for a consultation, who is familiar with the issues and the laws that are a concern to you, and consider hiring them to look after your needs. Similarly, although I am a psychologist, nothing in this book should be construed as providing anyone with any psychological advice or assistance of any type. If you are in need of psychological assistance, whether in dealing with your personal problems or with some issue requiring an expert witness, I recommend that you contact a psychologist and/or a lawyer and establish professional relationships with those individuals. Clearly, this book is a reference work intended to provide information about the nature of psychological evaluations in litigation that I have garnered from my years of working in the area and should not be used as a substitute for any professional relationship. Finally, please recall that I am an expert witness in psychology who gives testimony about his opinions in the area of psychology. As such, many of the things I have said in this book are just that, my opinions. I urge you to recognize that other professionals in the area may have ideas that are different than mine and will not agree with the things I have said in this book.
Chapter 1

Introduction: An Overview of Some Cases & Concepts

I. Personal Injury: Sally: A Case Study of a Physical Injury and a Psychological Injury

Sally Mason was driving along the Ventura Freeway in Los Angeles on a bright sunny day in May. She was on her way from Glendale to Thousand Oaks to visit her girlfriend Miriam, driving in the fast lane about 5 mph over the speed limit. In an otherwise unremarkable instant, and completely without warning, the sport utility vehicle in the next lane drifted over the bots and pushed into the left side of Sally’s sedan, forcing her into the low concrete median wall dividing the highway. After the initial bump, the first thing Sally was aware of was the screaming of the sheet metal on her left as it was being ground and ripped away from the vehicle’s frame by the concrete wall. In the next instant the left side of her front bumper bit into that wall and the right rear of her vehicle began to spin out into the adjacent lane. By now the SUV that had initially struck her had careened into the lane to its right and Sally’s left rear quarter panel, which was now in the wrong lane, was struck by the bobtail truck following the SUV. At that point Sally lost all awareness of what was happening as her senses became overwhelmed by the seemingly endless jolts and ear assaulting crashes. Her only emotion was fear. She thought she was about to die. However, despite these thoughts and emotions, everything ultimately came to a stop and the next thing she experienced was some Good Samaritan telling her not to move and that help was on the way. Well, help was on the way. Shortly thereafter the paramedics arrived, treated her and took her to a local hospital where the emergency room physician told her that although she had some soft tissue injuries nothing was broken. Aside from hurting for some weeks, the doctor said she would eventually get better and be as good as new. All of that proved to be true.

Unfortunately, what was not expected and what no one told Sally was that in the coming months she would have recurring nightmares of the accident; extreme fearfulness of driving on the freeway, even as a passenger; unexpected feelings as though the accident was recurring; difficulty falling asleep; irritability; a loss of
interest in sexual relations not explainable by her physical symptoms; a loss of interest in her cooking hobby; and feeling detached from her many girlfriends.

A few days after the accident her husband, Barry, who had taken charge of working out the details of getting the insurance company to pay for Sally’s completely destroyed car under their collision insurance policy, spoke to the insurance company adjuster. That adjuster indicated that he had not yet determined who was at fault for the accident. However, he said that when they did, if it was not Sally, they would try to get the Mason’s deductible back from that party. The adjuster also explained that the insurance company had a subrogation division that was staffed with a battalion of lawyers who did almost nothing else but work out these details. The adjuster further informed Sally’s husband that he too was free to hire an attorney to look after their interests. Although reluctant to do so, Barry thought that it might be best to protect their interests and hire an attorney, which he did on the recommendation of one of his tennis-playing friends.

Once Sally was up and around, she and Barry went to the attorney’s office. They were briefed on the procedures that would be followed, and filled out the necessary paperwork to hire the lawyer. Mr. Phillip, the attorney, told her that it would be best if she went to a doctor he recommended who would look after her needs and write reports that would be used in the event that there was some need for litigation, which he suspected there was, since this almost always seemed to be the case. That Friday, Sally went to Dr. Lipscomb, an orthopedist, who took another series of x-rays and confirmed the emergency doctor’s analysis that Sally had suffered a soft tissue injury that would eventually heal and she would be as good as new. He adjusted her medications and prescribed physical therapy, which Sally began the following Monday morning.

It was during the physical therapy that Sally became sufficiently friendly with Lynn, the therapist, to confide in her some of the unusual feelings and thoughts she was having. Given that Lynn had 12 years of treating accident victims, she quickly came to the conclusion that Sally had some form of a psychological injury as a result of the accident. The bad dreams, the fearfulness of driving, the insomnia,
the irritability, and the interruption in normal behavioral and social
events were all too familiar to her as symptoms or complaints
produced by the accident. She encouraged Sally to tell Dr. Lipscomb
about these complaints, which Sally did on her next visit, and Dr.
Lipscomb convinced her that she had to see a psychologist because,
although what she was feeling, thinking and doing was somewhat
typical for victims of what she had gone through, it was not something
she should be living with but something that could be fixed. After
some reluctance, Sally agreed, was referred to Dr. Mortoun, a
psychologist, and received counseling and treatment. Sally was in
treatment for five months at which time it became clear that most of
her symptoms had gone away and what remained was not getting
any better, although Dr. Mortoun assured her that there was a
reasonably good chance that they would fade with time.

In the meantime, Dr. Mortoun had written a report of his initial
evaluation that was forwarded to Dr. Lipscomb and her attorney, Mr.
Phillip. He subsequently wrote progress reports on a monthly basis
and at the conclusion of treatment he authored a final report detailing
Sally’s condition at the end of his treatment. In time, the insurance
company paid for the damage to Sally’s car, minus the deductible, as
well as the fees of Dr. Lipscomb, Dr. Mortoun, the physical therapy
group and some other medical practitioners who were consulted.
Meantime, Sally and Barry went back to their lives with the
understanding that it would take some time for Mr. Phillip to work out
what he said was an equitable settlement for her pain and suffering
that he told them was due to at least one other driver’s fault. What
Sally and Barry did not know is that this litigation process would go on
for two years and involve a great deal of subsequent medical
evaluations that Sally would have to attend as well as behind-the-
scenes paperwork and negotiating that they would not get to see.
Eventually Sally’s symptoms, her temporary psychological disability
and the litigation were resolved. Sally was left with no physical
symptoms and minimal psychological complaints and she received a
relatively small settlement for her pain, suffering and troubles.

What Sally and Barry did not see, and would probably never
understand, is that in order for that settlement to have occurred it was
necessary for multiple medical professionals to evaluate and write
reports that would allow the attorneys, insurance adjusters and
perhaps the judge and jury to arrive at an equitable settlement. Clearly, Sally had suffered a psychological injury, the extent of which was not an open and shut matter, but one that was subject to the medical opinions of psychologists and/or psychiatrists on both sides of the litigation.

II. On-the-Job Injury: Joe: A Case Study of a Pure “Stress” Injury

When Joe Chavez came back from the war in Vietnam, the first thing he wanted to do was get married and the second thing was to start a career in the police department in a Los Angeles suburb. Joe did exactly that, applying to the police department even before they rented the hall for the wedding. In due course, Joe was hired, he and Margo had two sons, and Joe ultimately rose in the department and became a detective in the robbery and homicide division. After 15 years on the force, Joe became involved in a case that would present him with the biggest trauma of his life. The case was a kidnapping and murder. The victim was an eight-year-old boy. Unfortunately for Joe, there was a small window of opportunity where he could have conceivably solved the case and rescued the young boy before he was ultimately murdered. Unluckily for Joe he did not make a vital connection that would have led him to the rescue. There was a departmental investigation that overwhelmingly came to the single conclusion that there was no way that Joe could have made the connection. He was completely absolved of any wrongdoing in the case and returned to active duty after a relatively short period of time spent on paid leave while the investigation was conducted.

Unfortunately for Joe, while he was restored to his job, things did not turn out well for him psychologically. Although he was found to have acted appropriately, blamelessly and professionally by an independent police review board, he did not let himself off the hook. He started ruminating about what he “should” have known, what he “should” have done and what “should” have happened. While these thoughts were not supported by his colleagues, or anyone else familiar with the case, Joe continued blaming himself for the boy’s death. Worse, once having started down that path, Joe became increasingly depressed. Where once he looked forward to work, he
now dreaded his job. He felt sad most of the day and at times would find himself breaking into tears. He lost interest in coaching his son’s Little League team. His appetite decreased and he found himself having one beer too many on more than just a few nights. He had trouble falling asleep and often found himself lying in bed ruminating about what he “should” have done and concluding that not having done so was his fault. At times he couldn’t concentrate at work and found it difficult to make decisions.

In a matter of weeks, Joe’s lieutenant noticed a major change in Joe’s behavior and brought it to his attention. Joe was very open about what was happening and explained to the lieutenant exactly what was going on. At that point it was clear that Joe could not do his job and that he would need some professional help to alleviate his depression. The risk management department at the city where Joe worked was consulted and Joe completed a workers’ compensation claim form that essentially stated that he was suffering from a psychological injury as a result of his experiences on the job. The head of the risk management department sent Joe to a psychologist for an evaluation and subsequent treatment. At the same time, Joe consulted with his union representative who referred him to an attorney simply “to protect your rights.” Joe went to that attorney who recommended a second opinion from another psychologist. As it turned out, the two psychologists drew somewhat different conclusions and the attorney convinced Joe it was in his best interest to file a workers’ compensation lawsuit, again to protect his rights.

Eventually, Joe got better, but not completely so. He was left with some residual psychological effects, namely a permanent disability, that will never go away. Nevertheless, he was able to return to his job, although with some partial psychological disability that was reasonably accommodated by the police department that assigned him to a different division. What would take almost three years to resolve was the litigation that ensued in which the focus was on the extent of Joe’s disability and the amount of compensation to which he was entitled. While there was some acrimony on both sides, a compromise was eventually arrived at and the situation put to rest.
III. Personal Injury and Workers’ Compensation Litigation

The two types of psychological injuries and the manner in which they are handled by the legal process is the subject matter of this book. In the case of Sally, she had a personal injury that is subject to civil litigation. In the case of Joe, he had a job-related injury that is subject to workers’ compensation litigation. These two areas of the law, while similar in some respects, are different in others. They are also different depending on the jurisdiction in which the injury occurs. However, the manner in which psychologists and related mental health professionals handle these cases is remarkably similar, regardless of the local jurisdiction. In many cases the professionals who handle them do an excellent job, documenting the injury and its cause and treating the patient. Unfortunately, in many cases they do not do an excellent job. What both systems have in common is that someone in a position of power, sometimes a judge, sometimes a jury, sometimes lawyers and insurance adjusters who are negotiating with one another, make decisions on the disposition of the case based on the evidence that is presented to them. Sometimes the evidence presented by one side or the other, and occasionally the evidence presented by both sides, is substantially flawed, grossly lacking in credibility and completely incapable of providing any information about the injured person’s psychological status.

Basically, forensic psychological services, much like auto repairs, are a “blind item.” In this regard, both psychology and car repairs often involve technical issues that the consuming public, whether they are lawyers, insurance adjusters, judges or just plain injured people, are not in a position to evaluate. Hopefully, this book will change that situation. In the coming pages I will discuss how a psychological examination should be conducted, how a report should be written and all of those substantial flaws I’ve found in 23 years of working in this area. Hopefully, a greater understanding of these mechanics will improve the quality of work in this area and reduce the number of miscarriages of justice.
IV. Psychologist and Psychiatrists

Before getting into the nature of psychological injuries I think it is worthwhile for me to distinguish between psychologists and psychiatrists. Psychologists are doctors who either have a Ph.D. or a Psy.D. degree. These are doctoral degrees. In order to get these degrees one must first have a four-year college degree and then have spent between three and about seven years studying psychology in graduate school. In the case of Ph.D.s the requirements of their doctoral programs place somewhat more of an emphasis on doing original research than the programs leading to Psy.D.s. There are a number of different specialties in psychology but typically if an individual specializes in clinical psychology, which involves evaluating and treating people, they must take an internship that requires training in the evaluation and treatment of patients. In most states they must have additional supervised experience after obtaining the doctoral degree in order to get a license to practice.

In contrast to psychologists, psychiatrists are medical doctors. In order to get their doctoral degrees, or M.D. degrees, they must first have a four-year college degree and then attend medical school, which is an additional three years. This is followed by an internship, in which they receive hands-on training in a wide variety of medical disciplines, and then a residency in psychiatry in which they specialize in treating mental disorders. Following their residency they typically have to pass a test given by the American Board of Medical Specialties in order to become “board certified,” although anyone with an M.D. degree and a license to practice medicine in a particular state can practice psychiatry.

Besides the above, the major differences between psychologists and psychiatrists are their training in psychological tests and psychotropic medicines. Psychologists typically have considerably more training and experience in administering and interpreting psychological tests. Those tests are invaluable in providing data and insights into an individual’s psychological status. In fact, they often provide the only objective data concerning an individual that is open to public inspection and can be presented to the court. On the other hand, with some exceptions in the military and in some states, the prescription of medications to treat mental
disorders is restricted to psychiatrists and other M.D.s. These two areas of expertise have some implications for the evaluation and treatment of mental disorders. Specifically, if you are concerned with the diagnosis of a mental disorder, the psychologist is in a better position to provide objective data concerning the person’s psychological status by using psychological tests to measure that status. However, once you know that a person has a specific disorder that is amenable or treatable with medication, the psychiatrist is the person who can intervene to provide that care.

V. Psychological vs. Psychiatric Injuries

Essentially, there is no difference between a psychiatric injury and a psychological injury. While at times various laws and legal personnel and documents may use the term “psychological injury,” and other laws, personnel and documents may use the term “psychiatric injury,” they are both referring to the same thing. A person who has had either a psychological injury or a psychiatric injury is simply an individual who has suffered from some environmental event that has left them with a mental disorder. For simplicity’s sake, and because I am a psychologist, throughout this book I will use the term “psychological injury” instead of “psychiatric injury,” although it should be understood that the terms are interchangeable.

VI. The Standard for Defining Psychological Injuries: The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders

A person is said to have had a psychological injury if some event has occurred that has led them to develop a psychological disorder that appears in the standardized diagnostic manual. They also can be said to have had a psychological injury if some event has occurred that led to an aggravation or exacerbation of a pre-existing psychological disorder that appears in that diagnostic manual. The standardized diagnostic manual that is agreed upon in virtually all contexts is the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, or what is sometimes called
the DSM. For most purposes it can be said that if an individual does not have a disorder that appears in the DSM they have not had a psychological injury.

From a psychological perspective the definition of a psychological disorder is always the same but the definition of a psychological or a psychiatric injury may be different in different legal jurisdictions. For example, according to the California workers’ compensation laws a person must have been working for their employer for at least six months in order to be said to have experienced a work-related psychiatric injury. Additionally, it must be found that the predominant cause of their injury, that is more than 50%, was an actual event of their employment. However, the law goes on to state that if the injury resulted from either a violent act, or from a direct exposure to a significant violent act, then only 35% to 40% of the cause of that injury has to be the result of the industrial event. Obviously, determining whether any given psychological injury meets the legal definition of such an occurrence can be difficult to determine since it depends on the local jurisdiction’s rules. However, determining if a psychological injury has occurred always starts with the question of whether the person has or has not, or is or is not, suffering from a DSM mental disorder.

The first edition of the DSM was published in 1952 and was based on a classification system initially adopted in 1918 by the United States Bureau of the Census. That original diagnostic manual has since been through five revisions as researchers have learned more about the nature of mental disorders. Through the years the successive DSMs have defined an increasingly large number of new disorders. The second edition, called the DSM-II, was published in 1968. This was followed by the DSM-III, published in 1980. In turn, the DSM-III was revised and called the DSM-III-R, with the “R” standing for the word “Revised.” That edition was published in 1987. The DSM-III-R was replaced by the DSM-IV in May, 1994. The current diagnostic manual was published in May, 2000 and is called the DSM-IV-TR, with the “TR” standing for “Text Revision” (American Psychiatric Association, 2000). The major difference between the DSM-IV and the DSM-IV-TR is that some of the specific criteria for diagnosing a disorder were changed in accordance with newly obtained research data and additional “up-to-date” information from
literature reviews that were published after the DSM-IV came out in 1994. The next revision of the DSM is scheduled to be called the DSM-V and will probably be published in 2012. Until then, the standard for diagnosing any mental disorder is the DSM-IV-TR.

VII. The Definition of a Psychological or Mental Disorder

Over the years the definition of a mental disorder has been changed as we have learned more about the nature of those disorders. The current definition of a mental disorder as found in the DSM-IV-TR is “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment on one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.” The DSM-IV-TR goes on to say that the syndrome or pattern that constitutes a disorder “must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a loved one.” Further, whatever the disorder causes, “it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual.” In relatively simple terms, at the very least, in order for an individual to have a mental disorder they must have some behavior or behaviors that are painful, disabling or have an increased risk of suffering death, pain, disability or a loss of freedom.

Clarity is one of the best things about the DSM-IV-TR in that in defining each and every one of the disorders the manual provides a list of the specific behaviors, thoughts and/or feelings that must be present in order to diagnose a specific disorder correctly. Thus, it is reasonable to expect that when a doctor diagnoses a specific DSM-IV-TR disorder there must be data in their report demonstrating that the person they have evaluated has shown that they meet the specific criteria found in the DSM-IV-TR. In this regard, if the individual does not meet the specific diagnostic criteria, they do not have a disorder and they have not had a psychological injury. Thus, regardless of how discomforted or upset they may appear to be, if their behavior does not demonstrate that they meet the diagnostic criteria, they have not had a psychological injury.
VIII. The Causes of Mental Disorders

In the most general sense, there are three sets of circumstances that produce mental disorders or psychological injuries. First, biological factors are known to produce some disorders. For example, while there is some disagreement among professionals, for quite some time it has been generally accepted that Schizophrenia is a brain disorder that is produced by some biological event, perhaps genetic, perhaps viral, or perhaps some combination of the two (e.g., Johnson, 1989). Additionally, as discussed at length below in Chapter 3, there is a whole category of mental disorders called Mental Disorders Due to a General Medical Condition. As we shall see these are psychological disorders due to the direct physiological consequences of a general medical condition.

A second set of mental disorders is produced as a result of a physical injury. A classic example of this type of an injury is an individual who has had a severe back injury and subsequently gets clinically depressed as a result of their incapacity. A wide variety of mental disorders can be produced by an equally wide variety of physical injuries.

The third type of injury is what has sometimes been called a “pure stress injury.” This is the type of injury where some aversive psychological circumstances in the person’s environment have produced a DSM-IV-TR psychological disorder. In the cases of Sally Mason and Joe Chavez, described above, both individuals had pure stress injuries, as there were no physical injuries that directly led to their psychological disorders. In the case of Sally Mason, although she was certainly physically injured in the automobile accident, that physical injury did not produce the psychological disorder.

IX. The Five DSM-IV-TR Diagnostic Axes

In order to make a complete DSM-IV-TR diagnosis, the reporting doctor must provide conclusions about the patient in five different areas. Providing information about these five areas gives the reader a summary of the doctor’s opinions that may be helpful not
only in understanding the patient, but also in planning their treatment and predicting the outcome of therapy.

For reasons not explained in the DSM-IV-TR, these five areas are called “Axes.” Clearly, this term is misleading as one might expect that when one is dealing with an axis that something can be expected to revolve around that axis. Nevertheless, the term “Axis” is used although I think it best that the reader consider them to be “Areas” describing the patient.

The five Axes are labeled numerically from 1 to 5 using Roman numerals. They are Axis I, Axis II, Axis III, Axis IV and Axis V. A sample Axis diagnosis showing the five Axes for a patient who is clinically depressed as a result of a physical injury is shown below. Almost every psychological evaluation report will provide a similar table, whether or not the person has a mental disorder.

Axis I - Depressive Disorder Not Otherwise Specified (311.00)

Axis II - No Diagnosis (V71.09).

Axis III - Physical Disorders and Conditions:  Mr. Washington is recovering from surgery needed to treat an injured spine.

Axis IV - Psychosocial and Environmental Problems: There are no known relevant psychosocial or environmental problems affecting Mr. Washington’s condition.

Axis V - Global Assessment of Functioning (GAF). Current GAF: 70. Highest GAF Past Year: 90. Mr. Washington has a psychological disorder that is interfering with his functioning in his normal areas of interest and activities such that he is not capable of working at his normal and customary job at his normal and customary capacity.

A reading of this Axes description of Mr. Washington indicates that, as shown on Axis I, he has a specific DSM-IV-TR psychological disorder called a Depressive Disorder Not Otherwise Specified. In the DSM-IV-TR each mental disorder is designated by a numerical diagnostic code. In the case of a Depressive Disorder Not Otherwise Specified, that number is 311.00. In an upcoming section I will
provide information on all of the frequently diagnosed mental disorders that occur in personal injury and workers’ compensation claims and litigation.

On Axis II there is no diagnosis. This simply means that Mr. Washington does not have any of the possible psychological disorders that are designated on Axis II. We will get to the different types of disorders that appear on Axis I and Axis II, below. At this point, suffice to say that the only disorders diagnosed on Axis II are Personality Disorders and Mental Retardation.

On Axis III Mr. Washington is described as recovering from back surgery. Since Axis III is used to describe physical conditions relevant to an understanding of the patient’s psychological condition, it is reasonable for the reader of this report to conclude that Mr. Washington’s clinical depression is due to, or has been exacerbated or aggravated by, his back injury. It is also reasonable to conclude that it is the doctor’s opinion that his back injury plays some role in his recovery from depression.

On Axis IV Mr. Washington is described as not having any psychosocial or environmental problems that would help the reader understand his psychological status.

On Axis V Mr. Washington’s Global Assessment of Functioning is described with two numbers. One summarizes his current overall or global level of functioning and the other describes the highest overall level of functioning he has had in the past year. Generally speaking, the longer a person has had a poor level of functioning the less likely they are to recover or show significant progress in a relatively short period of time. Similarly, the prognosis is better with relatively recently incurred low levels of functioning.

As implied above, all of the mental disorders that are found in the DSM-IV-TR, with the exception of Personality Disorders and Mental Retardation, are reported on Axis I. Axis I is also used to report conditions that may be a focus of clinical attention but are not mental disorders. I have already talked about the nature or definition of mental disorders and I will soon describe the principal disorders typically found in the areas of personal injury and workers’
compensation. At this point what is needed is a description of the nature of conditions that may be the focus of clinical attention but are not mental disorders.

Conditions that may be the focus of clinical attention but are not mental disorders are problems or conditions that people may have that come to the attention of mental health professionals but do not meet the definition for a mental disorder. For example, one of the most common conditions falling into this category is a Partner Relational Problem (V61.10). This condition is very easily understood as occurring when, for example, an individual seeks help from a mental health professional for assistance in solving a problem that is occurring in their marriage or in another partner relationship. Like all of the mental disorders, these conditions come with a numerical diagnostic code, in this case V61.10. Another common condition that comes to the attention of mental health professionals but is not a mental disorder is an Occupational Problem (V62.2). Occupational Problems are characterized by such conditions as job dissatisfaction and uncertainty about career choices. Clearly, many individuals seek the help of various mental health professionals in order to solve these problems, which are clearly not psychological disorders.

Finally, in considering Axis I it should be noted that it is possible for an individual to have more than one mental disorder and perhaps one or more other conditions that are not mental disorders. Under these circumstances all such disorders and/or conditions are described on Axis I.

As mentioned above, Axis II is used for describing Personality Disorders and Mental Retardation. Personality Disorders are lifelong patterns of maladaptive behavior that become evident no later than early adulthood. Personality Disorders are observed as enduring patterns of inflexible and pervasive behaviors that occur across a broad range of personal and social situations and lead to clinically significant distress or impairment in social, occupational and/or other important areas of functioning. The DSM-IV-TR defines 11 different Personality Disorders and in order to diagnose a Personality Disorder correctly, the doctor must obtain data indicating that there is a history demonstrating that the individual meets the criteria specified by the DSM-IV-TR. Axis II also may be used by the doctor to provide some
information about the individual’s personality traits or features that may be somewhat problematic for them but do not reach a level that constitutes a Personality Disorder. In this regard, personality traits or features are enduring patterns of perceiving, relating to and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts but are not sufficiently maladaptive to warrant concluding that the individual suffers from one of the Personality Disorders. Information about personality traits is typically provided by the doctor to give the reader what they believe is significant information that will be helpful in understanding the patient.

Moreover, as noted above, Axis II is also used for describing Mental Retardation, which is defined as significant subaverage general intellectual functioning that is accompanied by significant limitations in a variety of skilled areas such as communication and self-care and occurs before the age of 18. There are various types of Mental Retardation with those types being defined by performance on an Intelligence Test that yields an Intelligence Quotient (I.Q.) or score. Since the subject matter of this book is psychological injuries found in adults, and since Mental Retardation is a condition that begins at a young age, it is relatively unlikely that the issue of Mental Retardation of a psychologically injured person will be highly relevant to any such claim or litigation. Therefore, I have decided not to address that issue in this book.

Axis III is used for reporting general medical conditions, such as Mr. Washington’s back problem, that are potentially relevant to an understanding or the management of a mental disorder, in this case his Depressive Disorder Not Otherwise Specified. Virtually any medical condition can affect an individual’s psychological status. However, one cannot conclude that any given condition will have that affect independent of the individual. That is, simply knowing that an individual has, for example, heart disease is not sufficient to know that it will affect their clinical depression. Many people have severe physical problems that have virtually no affect on their psychological status. On the other hand, many people have very minor physical problems that can have a dramatic influence on their psychological status. It all depends on the person and how the illness affects them.
Axis IV is used for reporting any environmental or psychosocial problems or issues that may influence the diagnosis, treatment or potential outcome of therapy for a mental disorder that is defined on Axis I or Axis II. For example, if Mr. Washington was having severe financial difficulties as a result of his back problems, and this was affecting his depression, it would be relevant for the diagnosing doctor to provide that information on Axis IV.

Axis V is used by the doctor to provide information about the patient’s overall level of functioning, or what is called their Global Assessment of Functioning (GAF). The DSM-IV-TR provides a table from which the reporting clinician can pick a number from 1 to 100 that describes the patient’s level of functioning at the time of the evaluation, as well as their highest level of functioning during the preceding year. The higher the level of functioning the patient demonstrates, the higher the number and vice versa. Probably the principal use of this scale, beyond describing the individual’s current functional status, is to follow a patient during treatment as one would expect their level of functioning to go up as a result of therapy.

X. Psychology and Neuropsychology

Neuropsychology is an area of specialization in psychology that uses psychological tests and other psychological assessment techniques to provide information about an individual’s neurological status. In this regard, it is well known that neuropsychological evaluations are performed for the purpose of assessing possible neurological decrements. As such, the results of neuropsychological examinations are typically used by board certified neurologists who are attempting to assess neurological injuries that are relatively subtle and that might not necessarily be revealed with even state-of-the-art imaging techniques that are typically used in radiological examinations of the nervous system. In this regard, neuropsychologists are very adept at finding these subtle decrements as well as measuring more obvious impairments. In developing this specialized set of skills, neuropsychologists have obtained either a Ph.D. or a Psy.D. degree in psychology and have taken additional training in the area of neuropsychology. However, when a neuropsychologist evaluates a patient, the tests and evaluation
techniques they use typically do not provide any information concerning the likelihood of a psychological injury. Thus, while a neuropsychologist may draw some conclusions about a patient’s psychological status, those statements typically are not supported by the data of a more traditional psychological examination. Nevertheless, neuropsychologists often arrive at a DSM-IV-TR diagnosis such as Dementia Due to Head Trauma (294.1), a disorder discussed below in Chapter 3 that is characterized by multiple cognitive deficits, including memory impairments, and is caused by some traumatic head injury such as what might occur in an automobile accident. However, that diagnosis and similar DSM-IV-TR diagnoses are not indicative of a psychological disorder since they completely overlap diagnoses that would be made by a board certified neurologist. Accordingly, to consider the neuropsychologist’s diagnosis of these disorders as evidence of a psychological injury would be to support a double recovery for both a neurological injury and a psychological injury as a result of a single set of impairments. In short, although neuropsychological reports are a form of psychological reports written by psychologists they do not provide information about the possibility of a psychological injury.
Chapter 2

The Five Sources of Information

Psychologists draw diagnostic conclusions as a result of collecting and interpreting as many as five different sources of information or data. These data sources are: the results of the doctor’s Mental Status Examination, the person’s life history and presenting complaints as told by the individual, the results of the doctor’s psychological testing, an inspection of the person’s medical records and interviews with the individual’s friends, relatives and co-workers.

I. Mental Status Examination

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 allows 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. What the Mental Status Examination does not contain is information about the patient’s history or their complaints. The Mental Status Examination also does not provide any overall or general conclusions about the patient’s psychological status. The discussion of the Mental Status Examination simply reports the doctor’s observations of the patient’s behavior. Nevertheless, those observations can and will be used, in combination with the other data collected, to form conclusions about the patient.

II. Life History and Presenting Complaints

The Mental Status Examination is the first of two parts of the doctor’s face-to-face interview of the patient. The second part collects information about their life history and presenting complaints.
When thought of as a section of the doctor’s report, that section provides information about all of the relevant life history and psychological events in the patient’s life. During the interview of the patient the doctor should ask questions about the patient’s entire life, essentially finding out what happened to them from birth to the time they arrived at the doctor’s office. Included in this section of the report are data about where they have lived, their marital or significant other relationships, their family of origin including their parents and any siblings, their education, their employment history, their current physical and psychological complaints including why they think that have those complaints, their medical history, their history of substance usage, their legal history, their military history if any, and a history of their current activities.

III. Psychological Testing

Another set of data that is collected by the doctor, but not necessarily in a face-to-face manner, is the objective psychological testing data. Essentially, prior to the onset of any evaluation the doctor decides which tests to administer based on the information they need to obtain and the cost in time and/or money required to collect those data. Typically, a test battery provides information about any possible psychopathology, the patient’s personality traits, their cognitive abilities, and the possibility that some of their complaints may be due to an organic brain dysfunction.

IV. Review of Medical Records

In drawing conclusions about the psychological status of any patient, it is important to consider their medical history. Some of that history is obtained from the patient. However, another perspective on that history is obtained from doctors who have examined and treated the patient in the past. Information can also be obtained from other types of records, such as those from civil and criminal litigation and proceedings as well as any other sources of records that have been obtained concerning the patient. At times the medical records contain reports of investigations ordered by an insurance company as well as sub rosa video images of the patient engaging in a variety of
activities that might have some bearing on their claim of a physical and/or a psychological injury. On first look such undercover investigations may not appear to be fair, but rather an invasion of an individual’s privacy. However, once a person files a claim or a lawsuit alleging a psychological injury they have put their psychological status in question or at issue and the people defending against that lawsuit have a right to the information that might normally be considered private and untouchable.

V. Collateral Sources of Information

The final source of information is in the form of any collateral interviews that might be obtained. At times there are no such sources of information, while at other times it is possible to obtain relevant data from the patient’s friends, relatives and co-workers. This is especially important if the person being evaluated has limited communication skills as a result of psychopathology or other reasons. One such example occurs in cases of Mental Retardation, where the person who has been injured may not be capable of providing a complete history. Additionally, in extreme cases, the person being evaluated may not even be available, although their psychological status at some point in time is relevant. Imagine, for example, the person claiming the psychological injury died sometime after being injured. In those cases the only face-to-face interview data that can be obtained is from other people. Such evaluations are called psychological autopsies and are typically rare events in any medical-legal practice.
Chapter 3

The Most Frequently Diagnosed Disorders in Litigation

On first look, a reading of pages 857 to 866 of the DSM-IV-TR reveals that this diagnostic manual designates 360 different mental disorders. However, a further examination of the DSM-IV-TR indicates that the number is both substantially greater than 360, as well as unknown. This ambiguity is in part due to the DSM-IV-TR’s use of what are called specifiers to denote such things as the severity of a disorder as well as disorders that have resolved. For example, many disorders can be diagnosed as being Mild, Moderate, or Severe, as well as being In Full Remission, In Partial Remission and only present By History. Thus, when one considers all of the specifiers, the number of possible diagnoses is significantly greater than 360. Additionally, the total number of disorders is clearly ambiguous as a result of some of the DSM-IV-TR disorders being defined as being due to various medical conditions, and there is no information about how many different medical conditions can cause these various mental disorders. Thus, considering all of the combinations, there are well over 3,000 possible diagnoses.

A reading of the DSM-IV-TR also reveals that the disorders fall into broad classifications such as Adjustment Disorders, Anxiety Disorders, Mood Disorders, Substance-Related Disorders, Personality Disorders, Schizophrenia and Other Psychotic Disorders, Sleep Disorders, Somatoform Disorders, Mental Disorders Due to a General Medical Condition, Eating Disorders, Dissociative Disorders, Sexual Disorders, Gender Identity Disorders and Factitious Disorders. In addition there are many Conditions That May Be a Focus of Interest that are frequently seen in a medical-legal practice, although the DSM-IV-TR is very clear in indicating that these conditions are not mental or psychological disorders. Considering that there are so many possible diagnoses, such a massive amount of information could be confusing and intimidating. However, as we shall see, there is no reason to be overwhelmed.

Despite the relatively large number of disorders and conditions, experience has shown that not all of them are likely to appear in psychological claims or litigation alleging an adult has had a
psychological injury. Accordingly, I have not tried to describe all of
the DSM-IV-TR disorders in this volume, focusing instead on the
ones most likely to be encountered in litigation and claims in the
areas of personal injury and workers’ compensation. The only
exceptions I made are in considering the Dissociative Disorders, the
Eating Disorders, the Sexual Disorders and the Factitious Disorders.
In those cases, despite their relatively lack of frequency in actual
practice, I decided that a fairly comprehensive discussion of these
disorders would be important to have at one’s disposal. I also
somewhat arbitrarily decided not to include some disorders that have
a relatively low but not non-existent frequency in my clinical practice,
among which are the Learning and Communication Disorders, the
Attention-Deficit Hyperactivity Disorders, and the Impulse-Control
Disorders. Clearly, the reader is referred to the DSM-IV-TR for
information about these and any other disorders that they might
encounter that are not found in this work. Regardless, as found in my
practice the most frequently diagnosed disorders are the Adjustment
Disorders, the Anxiety Disorders, the Mood Disorders, the
Substance-Related Disorders and the Personality Disorders.
Nevertheless, most of the main classes of disorders and conditions
are discussed below. The order in which they are discussed
corresponds to the frequency with which they have been seen in my
medical-legal practice.

I. Adjustment Disorders

Adjustment Disorders are characterized by significant emotional
and/or behavioral signs and/or symptoms or complaints, which have
occurred in response to one or more identifiable psychosocial
stressors. For our purposes a psychosocial stressor, or simply a
stressor, can be considered to be a life event that produces strain or
tension that is difficult to endure or manage. In this regard, at this
point it is best to consider the difference between “signs,” “symptoms”
and “complaints.” A “sign” is observable or objective evidence of a
disorder. It is something that the doctor sees or hears with their own
eyes and/or ears. A “symptom” is synonymous with a “complaint”
and is something that the patient tells the doctor that they are
experiencing or have experienced. Of course signs and/or symptoms
or complaints may or may not be indicative of a psychological
disorder. The diagnosis always depends on all of the data, not just what the doctor observes or what the patient complains about.

Having gotten the nature of signs, symptoms and complaints out of the way, it is relevant to note that a stressor may be a single event or a series of events. In order to diagnose an Adjustment Disorder correctly the individual must show marked distress in response to that stressor, a response that is excessive for what has occurred and/or a significant impairment in social, occupational and/or academic functioning. Additionally an Adjustment Disorder can only be diagnosed if the pattern of abnormal behavior begins within three months of the onset of the stressful environmental event. Moreover, if the abnormal behavior persists for more than six months after the removal of the stressor, the DSM-IV-TR states that it is mandatory to diagnose something besides an Adjustment Disorder.

The most frequently diagnosed Adjustment Disorders are: an Adjustment Disorder With Mixed Anxiety and Depressed Mood (309.28), an Adjustment Disorder With Anxiety (309.24) and an Adjustment Disorder With Depressed Mood (309.0). The Adjustment Disorders are diagnosed according to their predominant signs and/or symptoms.

1. **Adjustment Disorder With Mixed Anxiety and Depressed Mood (309.28)**

   In the case of an Adjustment Disorder With Mixed Anxiety and Depressed Mood (309.28) the predominant manifestation of the Adjustment Disorder is a combination of anxiety and depression. Pathological anxiety and depression may exhibit itself in a multitude of ways.

   While everyone has at one time or another experienced anxiety or fears and/or worries, anxiety can be indicative of psychopathology if the individual presents with unrealistic fears and/or worries. Such patients will generally talk about or are said to have themes in their narrative of threat, danger, unpredictability, uncertainty or terror. Behaviorally, they may exhibit signs of fidgeting, restlessness, hand wringing, a strained voice, tremulousness, tension, motor
hyperactivity, jumpiness, autonomic hyperactivity, vigilance, scanning and/or poor reality testing. Further, they often complain of a variety of physical symptoms or complaints such as chest tightness or pain, shortness of breath, heart palpitations, racing heartbeats, choking and/or smothering, diarrhea, frequent urination, tingling sensations in the extremities, dizziness, lightheadedness, cold sweats, hot flashes, dry mouth, shaking, jitteriness and/or trembling.

Everyone gets depressed at one time or another, but pathological depression is typically observed as unrealistic sadness in which the individual may talk about feelings and/or thoughts of worthlessness, hopelessness, helplessness, incompetence, self-reproach, guilt, pessimism, failure, demoralization, a loss of interest in pleasure, and thoughts of death and/or suicide. They also may complain of fatigue, weight changes when not dieting or attempting to gain weight, insomnia, frustration, anger and/or 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. A combination of the above signs and/or symptoms, caused by an external stressor that occurred within the last three months, and have not continued for more than six months since the stressor went away is sufficient, when supported by other data obtained during the evaluation, to warrant the diagnosis of an Adjustment Disorder With Mixed Anxiety and Depressed Mood. For purposes of brevity, the comment of “when supported by other data obtained during the evaluation” is true for every diagnosis and will not be repeated in the discussion below.

2. Adjustment Disorder With Anxiety (309.24)

According to the DSM-IV-TR, an Adjustment Disorder With Anxiety (309.24) is diagnosed correctly when the predominant manifestations are signs and/or symptoms of anxiety.

As described above in conjunction with the diagnosis of an Adjustment Disorder With Mixed Anxiety and Depressed Mood, individuals with pathological anxiety generally have themes in their narrative of threat, danger, unpredictability, uncertainty or terror.
Behaviorally, they may show fidgeting, restlessness, hand wringing, a strained voice, tremulousness, tension, motor hyperactivity, jumpiness, autonomic hyperactivity, vigilance, scanning and/or poor reality testing. Further, they often complain of a variety of physical symptoms such as chest tightness or pain, shortness of breath, heart palpitations, racing heartbeats, choking and/or smothering, diarrhea, frequent urination, tingling sensations in the extremities, dizziness, lightheadedness, cold sweats, hot flashes, dry mouth, shaking, jitteriness and/or trembling. A combination of the above signs and/or symptoms caused by an external stressor that occurred within the last three months and have continued for not more than six months since the stressor went away is sufficient to warrant the diagnosis of an Adjustment Disorder With Anxiety.

3. **Adjustment Disorder With Depressed Mood (309.0)**

According to the DSM-IV-TR, an Adjustment Disorder With Depressed Mood (309.0) is diagnosed correctly when the predominant manifestations presented by the patient are signs and/or symptoms of depression in the form of a depressed mood.

As described above in conjunction with the diagnosis of an Adjustment Disorder With Mixed Anxiety and Depressed Mood, a pathologically depressed mood is exhibited by behaviors and thoughts revealing unrealistic sadness, worthlessness, hopelessness, helplessness, incompetence, self-reproach, guilt, pessimism, failure, demoralization, thoughts of death and/or suicide. There also may be complaints of fatigue, weight changes when not dieting or attempting to gain weight, insomnia, frustration, anger and/or decreased libido as well as signs of reduced cognitive functioning, psychomotor retardation or agitation, attention deficits, sadness, tearfulness, irritability, indecisiveness and evidence of social withdrawal. A combination of the above signs and/or symptoms caused by an external stressor that occurred within the last three months and have continued for not more than six months since the stressor went away is sufficient to warrant the diagnosis of an Adjustment Disorder With Depressed Mood.
The specific DSM-IV-TR diagnostic criteria for all of the Adjustment Disorders are given below.

A. The presence of behavioral and/or emotional signs and/or symptoms that have formed as a reaction to an identifiable stressor or stressors that has occurred within three months of the onset of the stressor or stressors.

B. The signs and/or symptoms are evidenced by one of the following:
   (1) Marked distress that is excessive for what has occurred.
   (2) A significant impairment in social and/or occupational functioning.

C. The disturbance does not meet the criteria for another Axis I disorder nor is it just an exacerbation of another DSM-IV-TR disorder.

D. Bereavement, which is a normal and expectable reaction to the death of a loved one, has been eliminated as a cause of the disturbance.

E. The signs and/or symptoms have not persisted for more than six months after the removal of the stressor.

II. Anxiety Disorders

As the name implies, DSM-IV-TR Anxiety Disorders are diagnosed correctly when an individual presents with a clinically significant behavioral or psychological pattern of distress and/or disability that is characterized by signs and/or symptoms of anxiety.

Clinically, anxiety is observed in a variety of ways including, but not limited to, unrealistic fears and/or worries; phobic avoidance of specific events or activities; thoughts of threat, danger, unpredictability, uncertainty or terror; physical symptoms of chest tightness or pain, shortness of breath, heart palpitations, racing heartbeats, choking and/or smothering, diarrhea, frequent urination, tingling sensations in the extremities, dizziness, lightheadedness, cold sweats, hot flashes, dry mouth, shaking, jitteriness and/or trembling not attributable to a physical disorder; and behaviors such as fidgeting, restlessness, hand wringing, a strained voice,
tremulousness, tension, motor hyperactivity, jumpiness, autonomic hyperactivity, vigilance, scanning and/or poor reality testing. In order to diagnose an Anxiety Disorder correctly there must be evidence that the individual’s response is not a normal reaction to what has occurred, but an excessive or abnormal reaction.

The Anxiety Disorders in the order in which they have been most frequently seen in my practice are: a Generalized Anxiety Disorder (300.02), a Posttraumatic Stress Disorder (309.81), an Anxiety Disorder Not Otherwise Specified (300.00), a Panic Disorder With Agoraphobia (300.21), a Panic Disorder Without Agoraphobia (300.01), a Specific Phobia (308.29), an Acute Stress Disorder (308.3), Agoraphobia Without History of Panic Disorder (300.22), a Social Phobia (300.2) and an Obsessive-Compulsive Disorder (300.3).

1. Generalized Anxiety Disorder (300.02)

According to the DSM-IV-TR, a Generalized Anxiety Disorder (300.02) is diagnosed correctly when an individual presents with excessive anxiety and worry in the form of apprehensive expectations that have been occurring on most days for at least six months. This anxiety and worry also must be shown to occur about a number of events and/or activities. In addition, the individual must find it difficult to control their anxiety and worries, and those anxieties and worries must be far out of proportion to the actual likelihood of the feared events and/or activities. The DSM-IV-TR diagnostic criteria are given below.

A. The individual must present with excessive anxiety and worry in the form of apprehensive expectations that have been occurring on most days for at least six months. This anxiety and worry also must be shown to occur about a number of events and/or activities.
B. The individual must find it difficult to control their anxiety and worries.
C. The anxiety and worry must be associated with three or more of the following signs and/or symptoms:
   (1) Feeling restless or “keyed up or on edge.”
(2) Easy fatigability.
(3) Having difficulty concentrating or having one’s mind go blank.
(4) Irritability.
(5) Muscle tension.
(6) Sleep disturbance in the form of difficulty falling and/or staying asleep and/or having restless and/or unsatisfying sleep.

D. The anxiety and worry must not be about having another disorder that is found on Axis I.

E. The individual must exhibit significant distress and/or impairment in social, occupational and/or other important areas of functioning.

F. The anxiety and worry is not due to the physiological effects of a substance and/or a general medical condition and does not occur exclusively during a Mood Disorder, a Psychotic Disorder or a Pervasive Developmental Disorder such as autism.

2. Posttraumatic Stress Disorder (309.81)

According to the DSM-IV-TR, a Posttraumatic Stress Disorder (309.81) is diagnosed correctly when an individual has been exposed to an extreme life-threatening traumatic stressor that has led to the development of a set of characteristic signs and/or symptoms that have lasted more than one month. These extreme life-threatening stressors may involve actual or threatened death, a serious injury, a threat to one’s physical integrity, witnessing such an event, or learning about such an event as having been experienced by a family member or close associate. Such traumatic events include, but are not limited to, military combat, violent personal assault, being kidnapped, being taken hostage, terrorists attack, torture, incarceration as a prisoner of war, natural or manmade disasters, severe automobile accidents or being diagnosed with a life threatening illness. The DSM-IV-TR diagnostic criteria are given below.
A. The person has been exposed to an extreme life-threatening traumatic event in which both of the following were present:
   (1) The person experienced, witnessed, or was in some other way confronted with an event in which there was an actual or threatened death or serious injury to him or herself or others.
   (2) The person responded to this event with intense fear, helplessness and/or horror.
B. The experience of the traumatic event has been persistently re-experienced in at least one of the following ways:
   (1) Distressing recollections of the event that are both recurrent and intrusive.
   (2) Distressing and recurrent dreams of the event.
   (3) Acting and/or feeling as if the traumatic event were recurring including flashbacks of the event in which the person may feel cut off from the episode as it is occurring.
   (4) When exposed to events and/or thoughts and feelings that resemble and/or symbolize the event, they experience intense psychological distress.
   (5) When exposed to events and/or thoughts and feelings that resemble and/or symbolize the event, they experience intense physical signs and/or symptoms.
C. The individual persistently avoids stimuli associated with the trauma and/or there is a numbing of their general responsiveness, as shown by the presence of three or more of the following:
   (1) The individual makes an effort to avoid thoughts, feelings, and/or conversations associated with the trauma.
   (2) The individual makes an effort to avoid activities, places, and/or people that bring back recollections of the trauma.
   (3) The individual displays an inability to recall an important aspect of the trauma.
   (4) The individual shows a marked diminished interest and/or participation in significant activities that they previously engaged in.
(5) The individual feels detached and/or estranged from others.
(6) The individual has a restricted range of affect or feelings that they previously had.
(7) The individual has a sense of having a shortened future as shown by expectations such as the belief that they will not have a normal life span, career, and/or family.

D. The individual shows persistent signs and/or symptoms of increased arousal as indicated by two or more of the following:
   (1) Difficulty initiating or maintaining sleep.
   (2) Irritability and/or outbursts of anger.
   (3) Difficulty concentrating.
   (4) Hypervigilance or a state of exaggerated oversensitivity to a class of events the purpose of which is to detect threats.
   (5) An exaggerated startle response, which is an overreaction to a sudden and unexpected occurrence.

E. The disturbances noted above have been present more than one month.

F. The disturbance noted above causes clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

3. **Anxiety Disorder Not Otherwise Specified (300.00)**

   According to the DSM-IV-TR, an Anxiety Disorder Not Otherwise Specified (300.00) is correctly diagnosed when the individual presents with “prominent anxiety or phobic avoidance that does not meet the criteria for another Anxiety Disorder.” As has previously been noted, pathological anxiety is typically observed when an individual presents with unrealistic fears and/or worries. These individuals may present with themes in their narrative of threat, danger, unpredictability, uncertainty or terror. They often complain of chest tightness or pain, shortness of breath, heart palpitations, racing heartbeats, choking and/or smothering, diarrhea, frequent urination, tingling sensations in the extremities, dizziness, lightheadedness, cold sweats, hot flashes, dry mouth, shaking, jitteriness and/or
trembling. Behaviorally, they often exhibit fidgeting, restlessness, hand wringing, a strained voice, tremulousness, tension, motor hyperactivity, jumpiness, autonomic hyperactivity, vigilance, scanning and/or poor reality testing. Phobic avoidance is observed as a marked and/or persistent fear that is excessive or unreasonable and occurs in a specific situation and is accompanied by the individual recognizing that their fear is excessive or unreasonable. Additionally, individuals with an Anxiety Disorder Not Otherwise Specified, as is the case of all individuals who have DSM-IV-TR psychiatric disorders, must be found to have evidence that their symptoms or behavioral and/or mental features are not simply a normal reaction to what has occurred, but an abnormal response to their life’s circumstances.

4. Panic Attacks

According to the DSM-IV-TR, a Panic Attack is not a disorder, but a sign and/or a symptom of many disorders. In this regard, a Panic Attack is defined as a discrete period of intense fear or discomfort in which four or more of 13 signs and/or symptoms occur that develop abruptly and usually reach a rapidly developed peak within ten minutes. Individuals who experience Panic Attacks describe the experience as intense and accompanied by such thoughts as imminent death, heart attack or stroke, or going “crazy.” Panic Attacks can occur in a variety of Anxiety Disorders but the signs and/or symptoms are the same. In order to conclude correctly that the individual has experienced a Panic Attack, they must present with at least four of 13 signs and/or symptoms given below.

A. Palpitations, or an abnormally rapid or a pounding heartbeat.
B. Sweating.
C. Trembling and/or shaking.
D. A sensation of shortness of breath and/or smothering.
E. Feelings of choking.
F. Chest pain or discomfort.
G. Nausea and/or abdominal distress.
H. Feelings of dizziness, unsteadiness, lightheadedness and/or faintness.
I. Derealization, which is a feeling of unreality and/or depersonalization, which is a feeling of being detached from oneself.
J. A fear of losing control and/or going crazy.
K. A fear of dying.
L. Numbness and/or tingling sensations.
M. Chills and/or hot flushes.

5. Agoraphobia

According to the DSM-IV-TR, Agoraphobia is not a disorder but a sign and/or a symptom of a number of different disorders. Accordingly, Agoraphobia is defined as the occurrence of anxiety or fear about being in places or situations from which escape might be difficult and/or embarrassing and/or in which assistance might not be available in the event of the occurrence of a Panic Attack. This anxiety or fear typically leads the individual to a pervasive avoidance of a variety of situations such as being home alone, leaving home alone, being in a crowd, or taking public transportation. The specific criteria for concluding that the individual has Agoraphobia are given below.

A. Anxiety about being in situations and/or places from which escape may be difficult and/or embarrassing, or in which help might not be available in the event of the occurrence of either a Panic Attack or panic-like signs and/or symptoms. Consequently, the individual avoids those situations and/or places such as being home alone or leaving home alone, crowds and taking public transportation.
B. The individual avoids situations and/or places or endures them with marked distress and/or requires the presence of a companion.
C. The signs and/or symptoms listed in Criteria A and B are not better accounted for by another disorder, for example, a Social Phobia or a Posttraumatic Stress Disorder.
6. Panic Disorder With Agoraphobia (300.21)

According to the DSM-IV-TR, a Panic Disorder With Agoraphobia (300.21) is diagnosed correctly when the individual presents with recurrent and unexpected Panic Attacks. There must also be at least one month of either persistent concern about having additional attacks, worry about the implications of the attacks or their consequences, or a significant change in behavior related to the attacks. In addition, the individual must present with signs and/or symptoms of Agoraphobia, which as discussed above, is anxiety or fear about being in places or situations from which escape might be difficult or embarrassing and/or in which assistance might not be available in the event of the occurrence of a Panic Attack or panic-like signs and/or symptoms.

7. Panic Disorder Without Agoraphobia (300.01)

According to the DSM-IV-TR, a Panic Disorder Without Agoraphobia (300.21) is diagnosed correctly when the individual presents with recurrent and unexpected Panic Attacks. There must also be at least one month of either persistent concern about having additional attacks, worry about the implications of the attacks or their consequences, or a significant change in behavior related to the attacks. In addition, there must be no Agoraphobia or anxiety about being in places or situations from which escape might be difficult and/or embarrassing in the event of a Panic Attack or panic-like signs and/or symptoms.

8. Specific Phobia (308.29)

According to the DSM-IV-TR, in order to diagnose a Specific Phobia (308.29) correctly the individual must show a persistent and marked fear of some clearly discernible, circumscribed situations or objects. More specifically the individual must exhibit the seven different signs and/or symptoms given below.

A. A marked and persistent fear that is excessive or unreasonable and is brought about by the presence or
anticipation of a specific object or situation such as dogs, flying or heights.

B. When exposed to the phobic stimulus there is almost invariably an immediate anxiety response or a Panic Attack.

C. The person recognizes that their fear is excessive or unreasonable.

D. The phobic situation is avoided or else endured with intense anxiety and/or distress.

E. The avoidance, anxious anticipation, or distress of the feared situation interferes significantly with the person’s life.

F. In individuals who are less than eighteen years old, the disturbance must have been present for at least six months.

G. The anxiety and/or phobic avoidance associated with the specific object or situation is not better accounted for by another mental disorder.

9. Social Phobia (300.2)

According to the DSM-IV-TR, the diagnostic criteria for a Social Phobia (300.2) consist of a marked, persistent and unrealistic and/or excessive fear of one or more social and/or performance situations in which the person is exposed to unfamiliar people and/or to the possible scrutiny of others. The DSM-IV-TR criteria for diagnosing this disorder are given below.

A. A marked and persistent fear of at least one social and/or performance situation. In those situations the person must be exposed to unfamiliar individuals and/or to what they perceive as the scrutiny of others. They also must fear that they will behave in a humiliating and/or embarrassing manner.

B. The individual’s exposure to the social situation typically provokes fear or anxiety that is connected to the situation and may take the form of a Panic Attack.

C. The individual recognizes their fear is excessive and/or unreasonable.

D. The individual either avoids the feared situation or tolerates it with intense anxiety and/or distress.
E. The individual’s reaction to the situation interferes with their normal activities and/or relationships and/or there is marked distress about having the phobia.
F. The individual has had the phobia for at least six months.
G. The phobia is not due to the direct physiological effects of a substance and/or a general medical condition and it is not better attributable to another psychological disorder.
H. If the individual has a general medical condition it is not related to the phobia.

10. **Acute Stress Disorder (308.3)**

According to the DSM-IV-TR, an Acute Stress Disorder (308.3) is diagnosed correctly when an individual has been exposed to an extreme traumatic stressor. In this regard, the individual must have experienced, witnessed, or been confronted with an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of him or herself or others. Additionally, either while experiencing the traumatic event, or after the event, the individual must have had a variety of signs and/or symptoms that have lasted for at least two days but that have not persisted beyond a month after the traumatic event. As noted in the DSM-IV-TR, if the disturbance has lasted for more than one month the clinician should consider diagnosing a Posttraumatic Stress Disorder. The DSM-IV-TR specifies the following signs and/or symptoms for an Acute Stress Disorder as follows:

A. The person has been exposed to an extreme traumatic event in which both of the following were present:
   (1) The person experienced, witnessed, or was in some other way confronted with an event in which there was an actual or threatened death or serious injury to him or herself or others.  
   (2) The person responded to this event with intense fear, helplessness and/or horror.
B. During and/or after the traumatic event the person has experienced three or more of the following dissociative signs and/or symptoms. In this regard, a dissociative sign and/or symptom is one in which there is a total or partial
disconnection between one’s memories, motivations, feelings, thoughts and/or behaviors.

(1) Feeling some sense of emotional detachment, numbness or an absence of responsiveness.

(2) A reduced awareness of their surroundings such as in feeling one is in a “daze.”

(3) Derealization, a feeling of unreality.

(4) Depersonalization, a feeling of being detached from oneself.

(5) Dissociative amnesia, an inability to remember some important part of the traumatic event.

C. The traumatic event is persistently re-experienced with at least one of the following:

(1) Recurrent images, thoughts, dreams, illusions, flashbacks or a sense of reliving the experience.

(2) Distress when exposed to reminders of the traumatic event.

D. The individual has experienced a pronounced avoidance of stimuli that arouse recollection of the trauma.

E. There are pronounced signs and/or symptoms of anxiety and/or increased arousal such as difficulty sleeping, poor concentration, hypervigilance and an exaggerated startle response.

F. The disturbance causes clinically significant distress and/or impairment in social, occupational and/or other areas of functioning.

G. The disturbance has had its onset within four weeks of the traumatic event and it has lasted at least two days but not more than four weeks.

H. The disturbance is not due to the direct physiological effects of a substance and/or a general medical condition and is not better accounted for by another psychological disorder.

11. Agoraphobia Without History of Panic Disorder (300.22)

According to the DSM-IV-TR, Agoraphobia Without History of Panic Disorder is similar to a Panic Disorder With Agoraphobia with the exception that there are no Panic Attacks but instead the individual is frightened of incapacitating and/or extremely
embarrassing panic-like symptoms. As such, in order to diagnose Agoraphobia Without History of Panic Disorder (300.22) correctly, the individual must present with anxiety about being in places or situations from which escape might be difficult and/or embarrassing and/or in which help might not be available in the event of having unexpected “panic-like symptoms” like those experienced in a Panic Attack. The exact DSM-IV-TR diagnostic criteria for Agoraphobia Without History of Panic Disorder are given below.

A. The individual must present with Agoraphobia that is related to the fear of developing panic-like symptoms that occur in Panic Attacks.
B. The individual must never have met the criteria for a Panic Disorder.
C. The disturbance is not due to the direct physiological effects of a substance and/or a general medical condition.
D. If a general medical condition is present the individual’s fear is in excess of what usually occurs in individuals having that general medical condition.

12. Obsessive-Compulsive Disorder (300.3)

According to the DSM-IV-TR, the essential features of an Obsessive-Compulsive Disorder (300.3) are recurrent obsessions and/or compulsions that are either substantially time-consuming, e.g., an hour a day, and/or cause marked distress and/or significant impairment. Additionally, the individual has recognized that their obsessions and/or compulsions are excessive or unreasonable.

Obsessions are defined in the DSM-IV-TR as “persistent ideas, thoughts, impulses and/or images that are experienced as intrusive and inappropriate and cause marked anxiety and/or distress.” Additionally, although the person may experience these obsessions as alien or inconsistent with their personality, i.e., ego-dystonic, they recognize that the obsessions are a product of their own mind. The most common obsessions are repeated thoughts about contamination, repeated doubts, a need to have things in a particular order, aggressive impulses or sexual imagery.
Compulsions are repetitive patterns of behavior in the form of rituals, such as cleaning, ordering, checking, counting, or repeating words silently. The goal of these compulsions is not pleasure or gratification but the prevention and/or reduction of anxiety or distress. Typically, the individual feels driven to perform these behaviors to reduce the distress of an obsession or to prevent a dreaded event. Compulsions are either clearly excessive or are not performed in a manner that would lead a disinterested observer to conclude that they are performed to cope with a realistic problem.

The specific DSM-IV-TR diagnostic criteria for an Obsessive-Compulsive Disorder are given below.

A. The presence of obsessions and/or compulsions.
B. The individual’s recognition that the obsessions and/or compulsions are excessive and/or unreasonable for the situation.
C. The obsessions and/or compulsions cause substantial distress, are time consuming in that they take more than an hour a day, and/or they significantly interfere with the individual’s normal functioning.
D. If another Axis I disorder is present the obsessions and/or compulsions do not occur exclusively as part of that disorder. For example, if the individual is diagnosed with Hypochondriasis, their obsessions and/or compulsions with regard to their health do not occur exclusively as part of their Hypochondriasis.
E. The disturbance is not due to the direct physiological effects of a substance and/or a general medical condition.

III. Mood Disorders

As one can expect, the predominant feature of all of the Mood Disorders is a pathological disturbance in an individual’s mood. Generally, these disorders are characterized by abnormal or unrealistic elevations or reductions in mood or affect. These abnormal elevations or reductions are called mania and depression, respectively. Mania is often observed as extreme and unrealistic euphoria and what is described in the DSM-IV-TR as an elevated,
expansive or irritable mood. Depression is often observed as an unrealistic sadness in which the individual may talk about or express such feelings and thoughts as worthlessness, hopelessness, helplessness, incompetence, self-reproach, guilt, pessimism, failure, demoralization and thoughts of death and/or suicide. Individuals who exhibit pathological mania or depression also have specific behaviors. The specific diagnostic criteria for each of the Mood Disorders are outlined in the DSM-IV-TR. The most frequently diagnosed Mood Disorders are a Major Depressive Disorder, Bipolar Disorders, a Depressive Disorder Not Otherwise Specified, a Dysthymic Disorder, A Cyclothymic Disorder and a Mood Disorder Not Otherwise Specified.

1. **Major Depressive Disorder**

A Major Depressive Disorder is a serious mood disorder that is characterized by a depressed mood and associated signs and/or symptoms. These signs and/or symptoms must be shown to have been present during the same two-week period and to represent a change from a previous level of functioning, and at least one of the signs and/or symptoms is either a depressed mood or a loss of interest in pleasure called anhedonia. The seriousness of this disorder most frequently requires that an individual be given significant antidepressant medication, psychotherapy, hospitalization and possibly electroconvulsive therapy.

Major Depressive Disorders fall into two categories: Recurrent or Single Episode. Recurrent Major Depressive Disorders are diagnosed correctly when the individual has had two or more Major Depressive Episodes. Single Episode Major Depressive Disorders are diagnosed correctly when the individual has had only one Major Depressive Episode.

According to the DSM-IV-TR, in order to diagnose a Major Depressive Disorder correctly, the individual must present with at least five of nine symptoms. In addition, as mentioned above, they must present with Symptom A and/or Symptom B on the list below, that is, either a depressed mood or a loss of interest in pleasure.
In presenting their diagnostic conclusions, the doctor must identify the severity of the disorder. If the individual presents with five or six depressive symptoms, the specifier “Mild” is used in diagnosing this condition. If the individual presents with “most of” the nine symptoms and “clear-cut observable disability (e.g., inability to work or care for children),” the appropriate diagnostic specifier is “Severe Without Psychotic Features.” In order to use the specifier “Moderate” the individual must have a severity of the disorder that is intermediate between Mild and Severe.

Additionally, the doctor can specify if the Major Depressive Disorder is in some stage of remission, by using the diagnostic specifiers of In Partial Remission or In Full Remission. In Partial Remission is the diagnostic specifier used if the full criteria for the disorder were previously met but at the time of the doctor’s evaluation only some of the signs and/or symptoms remained. In Full Remission is the diagnostic specifier used if there are no longer any signs and/or symptoms of the disorder but that it is still clinically relevant to note that the person had those signs and/or symptoms.

An inspection of the DSM-IV-TR reveals that the nine symptoms are as follows:

A. A depressed mood that is present most of the day and every day or nearly every day.
B. A markedly diminished interest or pleasure in all, or almost all, activities most of the day, every day or nearly every day.
C. A significant weight loss or weight gain while not dieting and/or a decrease or increase in appetite every day or nearly every day.
D. Insomnia or hypersomnia every day or nearly every day, which is a lack of restorative sleep or an overabundance of restorative sleep.
E. Psychomotor agitation or retardation, that is, excessive motor activity or a slowing of body movements, respectively, every day or nearly every day.
F. Fatigue or a loss of energy every day or nearly every day.
G. Feelings of worthlessness and/or excessive or inappropriate guilt every day or nearly every day.
H. Diminished ability to think or concentrate or indecisiveness, every day or nearly every day.
I. Recurrent thoughts of death, recurrent suicidal thoughts without a specific plan, or a suicidal attempt, or a specific plan for committing suicide.

Given that the diagnosing practitioner can determine if the Major Depressive Disorder is Single Episode or Recurrent, can distinguish between four levels of severity of the disorder, and can report if the disorder is In Partial Remission or In Full Remission, there are 12 different possible diagnoses of Major Depressive Disorders, each with a separate numerical diagnostic code. These are:

Major Depressive Disorder, Single Episode, Mild (296.21)
Major Depressive Disorder, Single Episode, Moderate (296.22)
Major Depressive Disorder, Single Episode, Severe Without Psychotic Features (296.23)
Major Depressive Disorder, Single Episode, Severe With Psychotic Features (296.24)
Major Depressive Disorder, Single Episode, In Partial Remission (296.25)
Major Depressive Disorder, Single Episode, In Full Remission (296.26)
Major Depressive Disorder, Recurrent, Mild (296.31)
Major Depressive Disorder, Recurrent, Moderate (296.32)
Major Depressive Disorder, Recurrent, Severe Without Psychotic Features (296.33)
Major Depressive Disorder, Recurrent, Severe With Psychotic Features (296.34)
Major Depressive Disorder, Recurrent, In Partial Remission (296.35)
Major Depressive Disorder, Recurrent, In Full Remission (296.36)

2. Bipolar Disorders

Bipolar Disorders are a group of disorders that all used to be incorporated under the diagnostic category called Manic-Depressive Illness. Individuals who suffer from these conditions typically experience major changes in their moods such as abnormally
elevated and/or depressed moods. While there are many different forms of Bipolar Disorders they are grouped into two types: Bipolar I Disorder and Bipolar II Disorder. Clearly, when one considers the many specifiers associated with each of these forms of Bipolar Disorders their diagnosis is by far the most complex and technical of all the diagnostic problems in the DSM-IV-TR. Nevertheless, it is possible to provide a clear and relatively simple discussion of these diagnoses.

3. **Bipolar I Disorder**

The DSM-IV-TR specifies that the essential feature of a Bipolar I Disorder is a clinical presentation in which there are one or more Manic Episodes or Mixed Episodes. A Manic Episode is defined by the presence of a distinct period during which there is an abnormally and persistently elevated, expansive or irritable mood. A Mixed Episode is characterized by a period of time of at least one week’s duration in which the criteria have been met for a Manic Episode and a Major Depressive episode nearly every day. Individuals with a Bipolar I Disorder also frequently have had one or more Major Depressive Episodes.

Bipolar I Disorders are classified according to whether the individual is experiencing a first episode (i.e., a Single Manic Episode) or whether the disorder is Recurrent. Recurrence is indicated by either a shift in the polarity of the episode or an interval between episodes of at least two months without manic symptoms. A shift in polarity is defined as a switching back and forth between mania and depression or between an elevated mood and a depressed mood.

Clearly, in order to diagnose a Bipolar I Disorder correctly it is necessary to understand the criteria for both a Manic Episode and a Mixed Episode and then to make certain that the individual presents with sufficient evidence of at least one of these episodes.
The diagnostic criteria for a Manic Episode are given below.

A. A distinct period of an abnormally and persistently elevated, expansive and/or irritable mood that lasts at least one week unless the person has been hospitalized in which case the duration is deemed irrelevant.

B. During the period in which they have had the mood disturbance the person must present with three or more persistent signs and/or symptoms unless their mood has been characterized by irritability in which case they must present with four such signs and/or symptoms.
   (1) Inflated self-esteem or grandiosity.
   (2) A decreased need for sleep such that the individual may feel rested after as little as three hours of sleep.
   (3) Increased talkativeness or pressure to keep talking.
   (4) A flight of ideas that is characterized by a continuous flow of accelerated speech with abrupt transitions from topic to topic, or the subjective experience that one’s thoughts are racing.
   (5) Distractibility as evidenced by one’s attention being too easily drawn to “unimportant or irrelevant external stimuli.”
   (6) An increase in goal-directed activity, socially, occupationally, educationally or sexually, or psychomotor agitation.
   (7) Excessive involvement in pleasurable activities that have a high probability of painful outcomes, such as sexual indiscretions, “foolish” business investments and unrestrained buying sprees.

C. The signs and/or symptoms do not meet the criteria for a Mixed Episode, as discussed below.

D. The disturbance in mood is sufficiently severe to cause a marked impairment in social and/or occupational functioning, or to require hospitalization, or there must be psychotic features such as delusions, hallucinations or grossly disorganized behavior.

E. The signs and/or symptoms are not due to the direct physiological effects of a substance and/or a general medical condition.
The diagnostic criteria for a Mixed Episode are given below.

A. The criteria are met for a Manic Episode and a Major Depressive Episode every day or nearly every day for at least one week. While it is necessary for the signs and/or symptoms of a Major Depressive Episode to have been present for at least a week, it is not necessary for those signs and/or symptoms to have been present for two weeks.

B. The disturbance in the individual’s mood is sufficiently severe to cause a marked impairment in social and/or occupational functioning, or to require hospitalization to prevent them from harming him or herself or others, or there must be psychotic features such as delusions, hallucinations or grossly disorganized behavior.

C. The signs and/or symptoms must not be due to the direct physiological effects of a substance and/or a general medical condition.

Most importantly, according to DSM-IV-TR criteria there are multiple types of Bipolar I Disorders that can be specified. Clearly, the type of Bipolar I Disorder that is diagnosed in any given case depends on whether there has been a single Manic Episode or Recurrent Manic Episodes, if the most recent episode is a Manic Episode or a Mixed Episode, or if the most recent episode is a Major Depressive Episode. It is also possible to diagnose a Bipolar I Disorder if the individual’s most recent episode has been a Hypomanic Episode, a condition normally occurring in Bipolar II Disorders, discussed below. Regardless, each of these different types of Bipolar I Disorder carries a different numerical diagnostic code.

Additionally, a further complication is that the DSM-IV-TR provides methods for the doctor to specify the severity of the disorder as Mild, Moderate, Severe Without Psychotic Features, Severe With Psychotic Features, In Partial Remission, In Full Remission and a catch-all category of “Unspecified” to be used when the doctor does not have sufficient information to make a decision. For each of these different possibilities there are distinct five digit numerical diagnostic codes that all begin with “296.” As noted in the DSM-IV-TR, when all of the above possible factors are taken into consideration there are
30 basic diagnoses for a Bipolar I Disorder, each designated by a different numerical diagnostic code.

As if this were not enough, there are also specifiers that the doctor can use to report additional conditions further describing the Bipolar I Disorder. These are: “With Catatonic Features,” “With Postpartum Onset,” “With Melancholic Features,” “With Atypical Features,” “With Full Interepisode Recovery,” “Without Full Interepisode Recovery,” “With Seasonal Pattern,” and “With Rapid Cycling.” Moreover, if there has been a Manic or Mixed Episode that is Severe With Psychotic Features the doctor can proceed to specify if those features are “Mood-Congruent Psychotic Features” or “Mood-Incongruent Psychotic Features.” Unfortunately, when one considers all of the mathematical possible combinations of specifiers, a full discussion of these factors is way beyond the scope of this text especially considering that Bipolar I Disorders are relatively rare. In this regard, while the sum total of all of the multiple types of Bipolar I Disorders has been estimated at about 1% in the general population, considering that there are hundreds of possible combinations, the likelihood of encountering any one of the possibilities is obviously substantially less than 1%.

4. Bipolar II Disorder

According to the DSM-IV-TR, a Bipolar II Disorder is diagnosed correctly when one or more Major Depressive Episodes has been accompanied by at least one Hypomanic Episode. A Hypomanic Episode is defined as a distinct period during which there is an abnormal and persistently elevated, expansive or irritable mood that lasts for at least four days. This period of abnormal mood must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity, a decreased need for sleep, a pressure of speech, a flight of ideas, distractibility, an increased involvement in goal-directed activities with psychomotor agitation and an excessive involvement in pleasurable activities, which have a high potential for painful consequences. If the mood is irritable rather than elevated or expansive, at least four of the above symptoms must be present.
The criteria for a Hypomanic Episode are given below.

A. A distinct period of a persistently elevated, expansive and/or irritable mood that lasts at least four days and is clearly different from the usual non-depressed mood.

B. During the period of the disturbed mood the individual must present with three or more of the following signs and/or symptoms (four if the individual’s mood is only irritable).
   1. Inflated self-esteem or grandiosity.
   2. A decreased need for sleep as characterized, for example, by the individual feeling rested after only three hours of sleep.
   3. Increased talkativeness or a pressure to keep talking i.e., a pressure of speech.
   4. A flight of ideas or the subjective experience that one’s thoughts are racing.
   5. Distractibility or behavior in which one’s attention is easily drawn to unimportant and irrelevant external events.
   6. Increased social, occupational, sexual and/or educational goal-directed activity and/or psychomotor agitation.
   7. Excessive involvement in pleasurable activities that have a high probability of leading to painful consequences, such as engaging in unrestrained buying sprees, sexual indiscretions or poor business investments.

C. The episode is characterized by a clear change in functioning from the individual’s normal or non-symptomatic level of functioning.

D. The disturbances in mood are observable by others.

E. The episode is not sufficiently severe to cause a marked impairment in social and/or occupational functioning and there are no psychotic signs and/or symptoms or a need for hospitalization.

F. The signs and/or symptoms are not due to the direct physiological effects of a substance and/or a general medical condition.
Most importantly, it should be noted that according to the DSM-IV-TR, all Bipolar II Disorders are specified with a single numerical diagnostic code, 296.89. However, there are actually multiple types of Bipolar II Disorders that can be verbally designated by using multiple specifiers. For example, the specific type of Bipolar II Disorder that is reported depends on whether the current or most recent episode is a Hypomanic Episode or a Major Depressive Episode. Additionally, if the current or most recent episode has been a Major Depressive Episode, the DSM-IV-TR provides methods for the doctor to specify the severity of the Major Depressive Episode as Mild, Moderate, Severe Without Psychotic Features, Severe With Psychotic Features, In Partial Remission, In Full Remission or Chronic. Further, with regard to the overall designation of a Bipolar II Disorder, the doctor can specify “With Catatonic Features,” “With Melancholic Features,” “With Atypical Features” “With Postpartum Onset,” “With Full Interepisodic Recovery,” “Without Full Interepisodic Recovery” in a “Seasonal Pattern” or “With Rapid Cycling.” Clearly, when one considers all of the many possible combinations, a full discussion of these many factors is beyond the scope of this text especially considering that Bipolar II Disorders are also relatively rare, with the sum total of all of the multiple types occurring in about .5% in the general population.

5. Depressive Disorder Not Otherwise Specified (311)

An inspection of the DSM-IV-TR reveals that a Depressive Disorder Not Otherwise Specified is diagnosed correctly when an individual presents with depressive features that do not meet the criteria for any other Depressive Disorder. Individuals who are clinically depressed may 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 complain of fatigue, weight changes when not dieting or attempting to gain weight, insomnia, frustration, anger and/or 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. Individuals with a Depressive Disorder
Not Otherwise Specified, as is the case of all individuals who have DSM-IV-TR psychiatric disorders, must be found to have evidence that their symptoms or behavioral and/or mental features are not simply a normal reaction to what has occurred but an abnormal response to their life’s circumstances.

6. Dysthymic Disorder (300.4)

According to the DSM-IV-TR, a Dysthymic Disorder (300.4) is diagnosed correctly when an individual has had a chronically depressed mood that is defined as one that has been present most of the day, more days than not, for at least two years. In addition, when depressed, at least two of the following additional symptoms are present: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. If the onset of the dysthymic symptoms is before the age of 21 the correct diagnosis is an Early Onset Dysthymic Disorder. If the onset of the dysthymic symptoms is after the age of 21 the correct diagnosis is a Late Onset Dysthymic Disorder. The specific DSM-IV-TR diagnostic criteria are given below.

A. The individual has had a depressed mood on a majority of the days, for most of the day, for at least two years.

B. During the depressions there have been two or more of the following:
   (1) Poor appetite or overeating.
   (2) Insomnia or hypersomnia.
   (3) Low energy or fatigue.
   (4) Low self-esteem.
   (5) Poor concentration or difficulty making decisions.
   (6) Feelings of hopelessness.

C. During the two-year period of depression the individual has not been without the signs and/or symptoms in A and B, above, for more than two months at a time.

D. No Major Depressive Episodes have occurred during the two-year period and the disturbance in mood is not better accounted for by another DSM-IV-TR disorder.
E. The person has never had a Manic Episode, a Mixed Episode or a Hypomanic Episode as typically found in Bipolar Disorders, and discussed above, nor have they had a Cyclothymic Disorder, as discussed below.

F. The disturbance in mood does not occur exclusively during the course of a chronic Psychotic Disorder.

G. The signs and/or symptoms are not due to the direct physiological effects of a substance and/or a general medical condition.

H. The signs and/or symptoms cause clinically significant distress and/or impairment in social, occupational and/or other areas of functioning.

7. **Mood Disorder Not Otherwise Specified (296.90)**

   According to the DSM-IV-TR, a Mood Disorder Not Otherwise Specified (296.90) is correctly diagnosed when the individual presents with mood symptoms that do not meet the criteria for any specific DSM-IV-TR Mood Disorder and in which it is difficult to choose between a Depressive Disorder Not Otherwise Specified and a Bipolar Disorder Not Otherwise Specified.

8. **Cyclothymic Disorder (301.13)**

   The essential feature of a Cyclothymic Disorder (301.13) is a mood disturbance that is chronic, fluctuating and involves numerous periods of hypomanic signs and/or symptoms and numerous periods of depressive signs and/or symptoms. Essentially, the individual has periods of relatively manic and depressive moods. In this regard, their hypomanic signs and/or symptoms are insufficient in number, severity, pervasiveness or duration to meet the criteria for a Manic Episode characteristic of a Bipolar I Disorder, and the depressive signs and/or symptoms are insufficient in number, severity, pervasiveness or duration to meet the criteria for a Major Depressive Episode. Further, it is unnecessary that any of the periods of hypomanic signs and/or symptoms meet either the duration or symptom criteria for a Hypomanic Episode characteristic of a Bipolar Disorder.
II Disorder. As specified in the DSM-IV-TR, individuals with a Cyclothymic Disorder must meet the following criteria:

A. For at least two years there have been numerous periods of hypomanic signs and/or symptoms and numerous periods of depressive signs and/or symptoms that do not meet the criteria for a Major Depressive Episode.

(1) Hypomanic signs and/or symptoms consist of:
(a) Inflated self-esteem or grandiosity.
(b) A decreased need for sleep as characterized, for example, by the individual feeling rested after only three hours of sleep.
(c) Increased talkativeness or a pressure to keep talking i.e., a pressure of speech.
(d) A flight of ideas or the subjective experience that one’s thoughts are racing.
(e) Distractibility or the behavior in which one’s attention is easily drawn to unimportant and irrelevant external events.
(f) Increased social, occupational, sexual and/or educational goal-directed activity and/or psychomotor agitation.
(g) Excessive involvement in pleasurable activities that have a high probability of leading to painful consequences, such as engaging in unrestrained buying sprees, sexual indiscretions or poor business investments.

(2) Depressive signs and/or symptoms include dysphoria, difficulty sleeping, feelings of hopelessness and helplessness, suicidal ideations, weight loss or weight gain when not trying to lose or gain weight, feelings of excessive guilt and feelings of worthlessness.

B. During the above-described two-year period the individual has not been without the signs and/or symptoms described in Criterion A for more than two months at a time.

C. No Major Depressive Episode, Manic Episode or Mixed Episode has been present during the first two years of the disturbance.
D. The signs and/or symptoms are not better accounted for by a Schizoaffective Disorder and are not superimposed upon Schizophrenia or another psychotic disorder.

E. The signs and/or symptoms are not due to the direct physiological effects of a substance and/or a general medical condition.

F. The signs and/or symptoms cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

IV. **Substance-Related Disorders**

Substance-Related Disorders are produced either by taking a drug of abuse, whether legal or illegal, or the side effects of medications and/or toxins. There is a wide range of chemical substances that can produce psychological disorders falling into this class. They include alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, nicotine, opioids, sedatives, anxiety reducing medications, analgesics, antihistamines, muscle relaxants, lead, pesticides, antifreeze, carbon monoxide, and paint, just to mention a few. The most frequently diagnosed Substance-Related Disorders fall into two categories: Substance Abuse and Substance Dependence.

1. **Substance Abuse Disorders**

According to the DSM-IV-TR, Substance Abuse is diagnosed properly when there is a maladaptive pattern of substance use characterized by recurrent and significant adverse consequences as a result of repeated substance use. In order to diagnose Substance Abuse correctly there must be significant impairment and/or distress, as shown by one or more of a series of substance-related events occurring within a 12-month period. The DSM-IV-TR criteria for Substance Abuse are given below.

A. A maladaptive pattern of using a substance that has led to a clinically significant impairment and/or distress that is shown
by one or more of the following signs and/or symptoms that have occurred during a 12-month period:

1. Recurrent use of a substance that has resulted in the failure to fulfill one’s obligations at work, school and/or at home.
2. Recurrent use of a substance in situations in which it is physically hazardous.
3. Recurrent use of a substance that has resulted in legal problems.
4. Continued use of a substance despite the fact that the individual has had persistent or recurrent social or interpersonal problems.

B. The signs and/or symptoms have never met the criteria for Substance Dependence.

As noted above, there are a myriad of substances that can be abused. A discussion of each of the Substance Abuse Disorders for those many substances is beyond the scope of this work. However, it can be noted that the most commonly abused substances are: alcohol, amphetamines and similar acting substances, cannabis, cocaine, hallucinogens, inhalants such as glue and paint thinners, opioids and similar acting substances, phencyclidine (PCP) and similar acting substances, and sedatives and similar acting substances such as hypnotics and anxiolytics or anxiety reducing agents. Finally, one can make a case that the most frequently used addictive substance in our society is nicotine. However, nicotine abuse is not defined by the DSM-IV-TR, which is very clear in stating that although nicotine is subject to Substance Dependence, it is very unlikely to result in Substance Abuse as the DSM-IV-TR defines that concept.

The essential diagnostic issues are whether or not the individual has or is using the substance, whether or not their use qualifies them for a diagnosis of Substance Abuse, and whether or not their use qualifies them for the more serious diagnosis of Substance Dependence, as discussed below. However, before passing on to the issue of Substance Dependence it should be noted that the DSM-IV-TR discusses two other sets of diagnoses: Substance Intoxication and Substance Withdrawal. In each case the diagnostic manual describes the state of intoxication produced by the
various substances that can be used, abused or dependent upon, as well as the signs and/or symptoms of the results of withdrawing from these substances. However, while these diagnoses are particularly colorful and interesting to read about and study, experience has shown that in the context of a medical-legal case Substance Intoxication and Substance Withdrawal are not issues that need to be considered.

Finally, just for the record, the various forms of Substance Abuse and their diagnostic codes are presented below. As you can see, the last two Substance Abuses bear the same diagnostic code. This is not a typographical error, or an error in the DSM-IV-TR, but is required by the need to coordinate the DSM-IV-TR numerical diagnostic codes with the numerical codes used by the World Health Organization’s *International Classification of Diseases, Ninth Revision, Clinical Modification* (1979), which is the official system of assigning diagnostic codes in all medical specialties in the United States.

Alcohol Abuse (305.00)
Cannabis Abuse (305.20)
Hallucinogen Abuse (305.30)
Sedative, Hypnotic, or Anxiolytic Abuse (305.40)
Opioid Abuse (305.50)
Cocaine Abuse (305.60)
Amphetamine Abuse (305.70)
Inhalant Abuse (305.90)
Phencyclidine Abuse (305.90)

2. Substance Dependence Disorders

A reading of the DSM-IV-TR reveals that the essential feature of all Substance Dependence Disorders is a group of cognitive, behavioral, and/or physiological signs and/or symptoms that reveal that the individual continues to use one or more substances “despite significant substance-related problems.” In all of the Substance Dependence Disorders there is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behavior as well as clinically significant
impairment and/or distress. The substances that can lead to
dependence are: alcohol, amphetamines and similar acting
substances, cannabis, caffeine, cocaine, hallucinogens, inhalants
such as glue and paint thinners, nicotine, opioids and similar acting
substances, phencyclidine (PCP) and similar acting substances,
sedatives, hypnotics and anxiolytics. The diagnostic criteria for
Substance Dependence are the same for all the substances upon
which one can become dependent and are given below.

In all cases of Substance Dependence there is a maladaptive
pattern of substance use that has led to clinically significant
impairment and/or distress as shown by three or more of the following
behaviors, thoughts and/or feelings occurring during any given 12-
month period.

A. Tolerance as defined by either a need to take a markedly
increased amount of the substance over time, in order to
achieve intoxication or the desired effect, or a markedly
diminished effect over time with continued use of the same
amount of the substance.
B. Withdrawal as shown by the characteristic signs and/or
symptoms for the substance as described in the DSM-IV-
TR, or, by use of the substance, or one that is closely
related, to avoid the withdrawal symptoms.
C. Frequently taking the substance in larger amounts or over a
longer period of time than was initially intended.
D. A persistent desire or unsuccessful attempts to reduce
either one’s consumption or to control its use in some other
way.
E. Spending a great deal of time obtaining the substance,
using the substance or recovering from its effects.
F. Giving up or reducing important social, occupational and/or
recreational activities as a result of using the substance.
G. Continued use of the substance despite knowing that one
has a persistent and/or recurrent physical and/or
psychological problem that has either been caused or
exacerbated by the use of the substance.
The various forms of Substance Dependence and their diagnostic codes are presented below.

Alcohol Dependence (303.90)
Cannabis Dependence (304.30)
Hallucinogen Dependence (304.50)
Sedative, Hypnotic, or Anxiolytic Dependence (304.10)
Opioid Dependence (304.00)
Cocaine Dependence (304.20)
Amphetamine Dependence (304.40)
Inhalant Dependence (304.60)
Phencyclidine Dependence (304.90)

3. Polysubstance Dependence (304.80)

Finally, there is one additional Substance Dependence Disorder that is relatively frequently found in medical-legal cases, Polysubstance Dependence (304.80). According to the DSM-IV-TR, Polysubstance Dependence is diagnosed correctly when an individual has repeatedly used at least three groups of substances during the same 12-month period, not including caffeine or nicotine, but no one substance predominated although the individual has met the criteria for Substance Dependence.

V. Personality Disorders

Personality Disorders are lifelong patterns of maladaptive behavior that become evident no later than early adulthood. Personality Disorders are defined as observable enduring patterns of inflexible and pervasive behaviors that occur across a broad range of personal and social situations and lead to clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning. In this regard, in order to diagnose a Personality Disorder correctly, it is necessary to demonstrate that the individual presents with a stable and long-lasting pattern of perceiving, relating to and thinking about the world and him or herself that causes significant functional impairment and/or subjective distress. The DSM-IV-TR defines 11 different Personality Disorders.
1. **Antisocial Personality Disorder (301.22)**

Individuals who have an Antisocial Personality Disorder present with a pervasive pattern of behavior that demonstrates a disregard for, as well as a violation of, the rights of others that began in childhood or early adolescence and has continued into adulthood. In non-diagnostic contexts these individuals are frequently labeled psychopaths or sociopaths. The DSM-IV-TR diagnostic criteria are given below.

A. Beginning by the age of 15 the individual must have shown a pervasive pattern of behavior that reveals a disregard for and a violation of the rights of others as demonstrated by three or more of the following criteria.

   (1) A failure to conform to social norms as shown by a lack of respect for lawfulness as indicated by repeated acts of illegal behavior.

   (2) A pattern of deceitfulness as shown by repeated occurrences of lying, using fictitious names, or cheating others for profit and/or pleasure.

   (3) Impulsivity and/or a failure to plan ahead.

   (4) Irritability and aggressiveness as demonstrated by multiple instances of physical altercations and/or assaults.

   (5) A reckless disregard for the safety of oneself or others.

   (6) A pattern of behavior demonstrating consistent irresponsibility as shown by repeated failures to demonstrate a consistent pattern of work and/or honoring of financial obligations.

   (7) A lack of remorse as shown by being indifferent to having hurt, mistreated or stolen from others or by rationalizing their behavior.

B. Having attained the age of 18.

C. There is evidence of a Conduct Disorder having been present before the age of 15 as demonstrated by a repetitive and persistent set of behaviors showing a violation of the basic rights of others and/or a violation of major age-appropriate social norms and/or rules. In order to conclude that this has occurred, three or more of the following types
of behaviors must have been shown in the prior 12 months with at least one behavior having been present in the previous six months: aggression to people and animals, the destruction of property, deceitfulness or theft, and serious violation of rules normally applicable to a 15-year-old.

D. The presence of the antisocial behavior does not occur exclusively during an episode of Schizophrenia or Mania.

2. **Avoidant Personality Disorder (301.82)**

   An Avoidant Personality Disorder (301.82) is characterized by an all-encompassing or pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to the negative evaluations of others as shown by the presence of four or more of the following signs:

   A. An avoidance of occupational activities that involve significant interpersonal contact as a result of fear of criticism, disapproval or rejection from others.
   B. An unwillingness to get involved with people unless they are assured of being liked.
   C. The exhibition of restraint within intimate relationships as a result of fears of being shamed or ridiculed.
   D. A preoccupation in social situations with thoughts of being criticized or rejected.
   E. Inhibitions in new interpersonal situations because of feelings of inadequacy.
   F. A perception of oneself as being socially inept, personally unappealing or inferior when compared to others.
   G. An unusual reluctance to take personal risks or to engage in new activities because of a fear that they may prove embarrassing.

3. **Narcissistic Personality Disorder (301.81)**

   Individuals who have a Narcissistic Personality Disorder demonstrate a pervasive or all-encompassing pattern of behavior showing grandiosity of thoughts and feelings about themselves, a
need for admiration and a lack of empathy that occurs in a wide variety of situations. These thoughts and feelings must be characterized by five or more of the following:

A. A grandiose or pretentious sense of self-importance that is not supported by objective assessment of the individual’s achievements.
B. A preoccupation with thoughts or fantasies of unlimited success, power, brilliance, beauty or ideal love.
C. A belief that he or she is “special” and unique and can only be understood by or associate with individuals or institutions having a similar “special” quality.
D. A need for excessive admiration.
E. A sense of entitlement as demonstrated by unreasonable expectations of favorable treatment or automatic compliance with those expectations.
F. Behaviors demonstrating interpersonal exploitation in that they take advantage of others to achieve their goals.
G. A lack of empathy in that they are unwilling or unable to understand another person’s state of mind, including their thoughts and feelings, and an inability to experience those thoughts and feelings from the other person’s point of view.
H. Enviousness of others or the belief that others envy them.
I. Arrogance and disdainfully proud behavior and attitudes towards others.

4. **Dependent Personality Disorder (301.6)**

Individuals who have a Dependent Personality Disorder show a pervasive and excessive dependency or a need to be taken care of by others that results in submissive and clinging behavior in an attempt to ward off rejection. They also demonstrate a fear of separation from the individuals that they have become dependent upon. These behaviors must be exhibited in a variety of contexts and be demonstrated by five or more of the following:

A. Difficulty making simple or everyday decisions without an excessive amount of reassurance and advice from significant others.
B. A need for others to assume responsibilities for most major areas of one’s life.
C. Difficulty expressing their disagreement with others because of an unrealistic fear of a loss of approval or support.
D. Difficulty doing things on their own because of a lack of confidence in one’s abilities.
E. Engaging in behaviors requiring them to go to excessive lengths, including volunteering to do things that are unpleasant, to obtain support and nurturance from significant others.
F. Feelings of discomfort and helplessness when they are alone because of unrealistic fears of not being able to care for themselves.
G. Urgently searching for a new relationship to provide care and support when a close relationship ends.
H. An unrealistic preoccupation with fears of being left alone to take care of themselves.

5. **Borderline Personality Disorder (301.83)**

According to the DSM-IV-TR, the essential feature of a Borderline Personality Disorder (301.83) is a pervasive pattern of instability in interpersonal relationships, affects or feelings, and self-image that is accompanied by marked impulsivity that is found in a variety of situations. In order to diagnose a Borderline Personality Disorder correctly, the individual must present with five or more of the following:

A. Frantic efforts aimed at avoiding either real or imagined abandonment by significant others.
B. A pattern of unstable and intense interpersonal relationships in which the other person is alternately perceived as unrealistically positive or unrealistically negative.
C. A disturbance in identity as exhibited by a marked and persistently unstable self-image or sense of self that is observed as major shifts in feelings about oneself.
D. Impulsivity that is found in at least two potentially self-damaging areas such as sexual activity, substance abuse and/or binge eating.
E. Repeated self-mutilating behavior, suicidal behaviors, threats of suicide and/or “suicidal gestures” in which the individual has seemingly acted to take their own life but in reality was not fully committed to doing so.

F. Instability of feelings or affects that is due to a marked reactivity of mood as shown by intense episodes of such feelings as dysphoria, irritability and/or anxiety lasting a few hours or rarely for a few days.

G. Longstanding feelings of emptiness.

H. Inappropriate or intense anger and/or difficulty controlling anger as shown in frequent displays of temper, constant anger and/or recurrent physical fights.

I. Brief periods of stress-related paranoid ideation and/or severe dissociative signs and/or symptoms such as a psychologically induced amnesia.

6. Histrionic Personality Disorder (301.50)

According to the DSM-IV-TR, an individual with a Histrionic Personality Disorder presents with evidence of a pervasive pattern of excessive emotionality as well as attention-seeking behavior. These individuals are often said to be “lively and dramatic” and are uncomfortable or feel unappreciated when they are not the center of attention. Additionally, this pervasive behavioral pattern must be present in a variety of contexts, as indicated by five or more of the following:

A. Feelings of discomfort in situations in which they are not the center of attention.
B. Interactions with others that are frequently characterized by inappropriate sexually seductive and/or provocative behavior occurring in a variety of contexts.
C. Shallow and rapidly shifting expressions of emotions.
D. Consistent use of one’s physical appearance to draw attention to oneself.
E. Speech that is characterized as being excessively impressionistic and lacking in detail.
F. Excessive displays of emotion in the areas of self-dramatization, theatricality, and exaggerated emotionality.
G. Suggestibility as shown by being easily influenced by circumstances or other people.
H. A belief that there is more intimacy in their relationships than actually exists.

7. Obsessive-Compulsive Personality Disorder (301.4)

According to the DSM-IV-TR, an Obsessive-Compulsive Personality Disorder is correctly diagnosed when the individual presents with a pervasive pattern of “preoccupation with orderliness, perfectionism and mental and interpersonal control at the expense of flexibility, openness and efficiency.” This pattern of behavior must be observable in a variety of contexts and the individual must present with four or more of the following signs and/or symptoms:

A. A preoccupation with rules, lists, order, organization, details and schedules to a point in which the purpose of those activities is lost in favor of simply following the rules, lists, schedules, etc.
B. An exhibition of perfectionism that is shown to interfere with the completion of tasks because the strict standards they set for their behavior are not met.
C. An excessive devotion to work and productivity that is not due to economic necessity, to the point of excluding leisure activities and friendships.
D. An overconscientiousness, scrupulousness and inflexibility about matters related to ethics, values and/or morality that are not due to cultural or religious affiliation.
E. An inability to discard worthless or worn-out objects even though they have no sentimental value.
F. A reluctance to delegate work or tasks to colleagues or employees unless those individuals agree to perform exactly as requested.
G. An adoption of a “miserly spending style” towards oneself and others and viewing money as a commodity to be hoarded for “future catastrophes.”
H. Rigidity and stubbornness.
8. Paranoid Personality Disorder (301.0)

The essential feature of a Paranoid Personality Disorder is an all-encompassing pattern of behaviors that is characterized by suspiciousness and distrust of others accompanied by an interpretation of their motives as being malevolent. These individuals are typically wary of other people and given to the belief that others will harm, deceive and/or exploit them. These behaviors, thoughts and feelings must be shown to occur in a wide variety of contexts, and the individual must present with four or more of the following:

A. A suspicion that other people are exploiting, harming or deceiving them.
B. A preoccupation about the loyalty or trustworthiness of friends and/or associates that is not justified by an objective assessment of reality.
C. A reluctance to confide in others that is based on the unwarranted fear that their confidence will be violated and “maliciously” used against them.
D. The perception of benign remarks or events as having hidden demeaning and/or threatening meanings.
E. A persistent bearing of grudges against others to the point of not forgiving insults, injuries or slights.
F. Mistakenly perceiving attacks on their character and/or reputation and over-reactions to these misperceptions in an angry manner and/or counterattacking the perceived source of the attacks.
G. Unwarranted and recurrent suspiciousness concerning the fidelity of one’s spouse or sexual partner.

9. Schizoid Personality Disorder (301.20)

According to the DSM-IV-TR, the essential feature of a Schizoid Personality Disorder is the presentation of a pervasive pattern of behavior in a variety of interpersonal settings in which the individual shows a detachment from social relationships and a restricted range of emotional expressiveness. These individuals typically appear to have a lack of desire for intimacy, appear indifferent to chances to develop close relationships and seemingly do not derive much
satisfaction from familial and/or social groups, preferring to spend
time by themselves. Specifically, the individual also must present
with four or more of the following:

A. An absence of an enjoyment in, and a lack of a desire for,
close relationships including those normally found in families.
B. A preference for solitary activities resulting in a high
frequency of choosing to be alone.
C. Little or no interest in sexual experiences with another
person.
D. Anhedonia or a lack of pleasure in all except perhaps a few
activities.
E. A lack of close friends and/or confidants other than for
parents, siblings and offspring.
F. Seems to be indifferent to the criticism or praise of others.
G. Emotional coldness, detachment and/or flattened affect.

10. Schizotypal Personality Disorder (301.22)

According to the DSM-IV-TR, the essential feature of a
Schizotypal Personality Disorder is a pervasive pattern of social and
interpersonal deficits that is accompanied by an acute discomfort with
close relationships as well as a diminished capacity for those
relationships. These individuals also show the presence of cognitive
and/or perceptual distortions as well as behavioral eccentricities. In
order to diagnose a Schizotypal Personality Disorder correctly, the
individual must exhibit five or more of the following diagnostic criteria:

A. Ideas of reference as observed by a pattern of beliefs that
external events and activities have a special significance for
the person. There must also be an absence of delusions of
reference, which are delusional beliefs that certain people
events, or things in one’s environment have a special
significance.
B. Odd beliefs or “magical thinking” that influences the
individual’s behavior, such as the belief that one has
magical control over others or can influence events with
magical rituals. These beliefs are not indicative of “normal”
superstitiousness, or a belief in such things as clairvoyance and telepathy.

C. Unusual perceptual experiences, such as sensing the presence of another person who is not there.

D. Odd thinking and speech, such as vague, circumstantial, metaphorical, over-elaborate, or stereotyped speech, including unusual or idiosyncratic phrasing and sentence construction that may be vague and/or digressive without incoherence.

E. Suspiciousness and/or paranoid thoughts or ideation.

F. Inappropriate or constricted affect as demonstrated by not having a full range of emotions that are typically required for successful relationships.

G. Odd, eccentric and/or peculiar behavior as seen in unusual mannerisms or an unkempt or non-traditional manner of dress as well as inattentiveness to normal social conventions.

H. A lack of close friends or relatives other than other than for spouses, parents, siblings and offspring.

I. Excessive anxiety in social situations that does not decrease as a result of familiarity and tends to be associated with paranoid fears as compared to negative judgments about themselves.

11. Personality Disorder Not Otherwise Specified (301.9)

According to the DSM-IV-TR, in order to diagnose a Personality Disorder Not Otherwise Specified (301.9) it is necessary to demonstrate that the individual presents with an enduring pattern of inflexible and pervasive behaviors that causes significant functional impairment and/or subjective distress but does not have one of the above-described ten specific Personality Disorders defined by the DSM-IV-TR.

VI. Schizophrenia and Other Psychotic Disorders

Schizophrenia and the other Psychotic Disorders are characterized by signs and/or symptoms of delusions and/or
hallucinations and to a lesser extent by disorganized speech or behavior and at times catatonic motor behavior. The essential feature of a hallucination is a perception that is not produced by an external event. Hallucinations can occur in any sensory modality in that they can be heard, seen, felt, smelt and tasted. However, auditory hallucinations are the most common hallucinations in the Psychotic Disorders. Delusions are erroneous beliefs that involve a misinterpretation of perceptions or experiences that are firmly held in spite of substantial evidence to the contrary. Disorganized thinking is observed in disorganized speech, such as verbal communication that does not make any sense in the context of the conversation and at times may be totally incomprehensible. Disorganized behavior may show itself in a variety of ways such as childlike silliness, unpredictable agitation and difficulty performing normal activities of daily life such as maintaining personal hygiene. Catatonic motor behavior may be seen as a marked decrease in reactivity to the environment, a complete lack of responsiveness, the assumption of inappropriate and/or bizarre positions, and/or purposeless activity.

There are five types of Schizophrenia: Schizophrenia, Disorganized Type (295.10); Schizophrenia, Catatonic Type (295.20); Schizophrenia, Paranoid Type (295.30); Schizophrenia, Residual Type (295.60) and Schizophrenia, Undifferentiated Type (295.90). Of the five types, Schizophrenia, Catatonic Type is quite rare and unlikely to be seen in the context of litigation.

As you might expect, all five types of Schizophrenia share a core of diagnostic criteria. In order to diagnose any form of Schizophrenia correctly the individual must meet the minimum criteria in this core.

1. **Diagnostic Criteria for all of the Five Forms of Schizophrenia**

In order to diagnose any form of Schizophrenia correctly the individual must present with:

A. A characteristic set of signs and/or symptoms in which two or more of the following have been present during a one
month period or for a lesser amount of time if there has been successful treatment:

(1) Delusions or erroneous beliefs that involve a misinterpretation of perceptions or experiences that are firmly held in spite of substantial evidence to the contrary.

(2) Hallucinations or perceptions in any sensory modality that are not produced by an external event.

(3) Disorganized speech as shown by incoherence and/or derailment or a tendency for ideas to “slide” from one “track” onto an unrelated or an indirectly related “track.”

(4) Grossly disorganized and/or catatonic behavior.

(5) Negative signs and/or symptoms in the form of flattened affect; alogia, which is an impoverishment of thought and/or speech; and/or avolition, which is an inability to initiate or sustain purposeful activities.

B. During a significant portion of the time since the onset of the psychological disturbance there has been a marked reduction in one or more major areas of social and/or occupational functioning such as work, interpersonal relations and self-care.

C. There have been continuous signs of the psychological disturbance for at least six months during which there has been at least a one month period of signs and/or symptoms found in Criterion A, although this one month criterion may be less if there has been successful treatment. This one-month period may also be constituted of prodromal (precursor) or residual signs and/or symptoms. If there are such prodromal or residual signs and/or symptoms it is sufficient that there are only negative signs and/or symptoms or two or more of the signs or symptoms in Criterion A presented in an attenuated form.

D. The criteria for Schizoaffective and a Mood Disorder With Psychotic Features have been ruled out.

E. The signs and/or symptoms are not due to the direct physiological effects of a substance and/or a general medical condition.
F. If there is a history of a Pervasive Developmental Disorder such as autism, the diagnosis of Schizophrenia is only made if prominent hallucinations and/or delusions have been present for a month, or less if successfully treated.

2. Additional Diagnostic Criteria for Schizophrenia, Disorganized Type (295.10)

In order to diagnose Schizophrenia, Disorganized Type correctly there must be disorganized speech, disorganized behavior, flat or inappropriate affect and the absence of the criteria needed to diagnose Schizophrenia, Catatonic Type (295.20).

3. Additional Diagnostic Criteria for Schizophrenia, Catatonic Type (295.20)

In order to diagnose Schizophrenia, Catatonic Type correctly the individual must present with a pattern of dominant signs and/or symptoms consisting of at least two of the following:

A. Motoric immobility as shown by catalepsy, which is a mental state in which a person’s muscles are partly rigid, or stupor, which is a state of lethargy or unresponsiveness.
B. Excessive motor activity that appears to be purposeless and is unaffected by external events.
C. Extreme negativism that is seen either as motiveless resistance to instructions or as the maintenance of a rigid posture that is resistant to attempts by others to move that posture, or mutism.
D. Peculiarities of voluntary movement as shown by the voluntary assumption of inappropriate and/or bizarre postures or stereotyped movements, prominent mannerisms or prominent grimacing.
E. Echolalia, which is the parrot-like repetition of overheard words and/or fragments of speech, or echopraxia, which is the seemingly automatic or uncontrollable imitation of other people’s movements.
4. Additional Diagnostic Criteria for Schizophrenia, Paranoid Type (295.30)

In order to diagnose Schizophrenia, Paranoid Type correctly the individual must present with a preoccupation with one or more delusions and/or frequent auditory hallucinations. They also must not present with prominent disorganized speech, disorganized or catatonic behavior or flat or inappropriate affect.

5. Additional Diagnostic Criteria for Schizophrenia, Residual Type (295.60)

In order to diagnose Schizophrenia, Residual Type correctly the individual must present with a history of at least one episode of Schizophrenia. However, at the time they are evaluated they are without prominent positive psychotic signs and/or symptoms although there is continuing evidence of a psychological disturbance. More specifically, the individual must not present with prominent delusions, hallucinations, disorganized speech, and/or grossly disorganized or catatonic behavior. Nevertheless, there must be some evidence of a continuing disturbance as shown by the presence of either negative signs and/or symptoms in the form of flattened affect, impoverishment of thought and/or speech (alogia), and/or an inability to initiate or sustain purposeful activities (avolition) or two or more of the overall signs and/or symptoms of Schizophrenia in an attenuated form such as delusions, hallucinations, disorganized speech, disorganized behavior and/or catatonic behavior, or negative signs.

6. Additional Diagnostic Criteria for Schizophrenia, Undifferentiated Type (295.90)

This diagnostic classification is used for individuals who present with sufficient signs and/or symptoms to diagnose Schizophrenia as determined by their meeting the conditions outlined in Criterion A but who do not meet the criteria for diagnosing the Paranoid, Disorganized or Catatonic Types of Schizophrenia.
7. **Schizoaffective Disorder (295.70)**

According to the DSM-IV-TR, a Schizoaffective Disorder (295.70) is a Psychotic Disorder that is diagnosed correctly when the individual presents with an uninterrupted period during which there has been a Major Depressive Episode, a Manic Episode or a Mixed Episode and those episodes have occurred in the same timeframe as the delusions or hallucinations characteristic of Schizophrenia. Additionally, those delusions or hallucinations have to have been present for at least two weeks in the absence of prominent mood signs and/or symptoms.

If the individual’s history and presentation reveals a Manic or Mixed Episode, as defined by and typically found in Bipolar I Disorder, the appropriate subtype of the Schizoaffective Disorder is “Bipolar Type.” If only Major Depressive Episodes are part of the presentation, the correct subtype of the Schizoaffective Disorder is “Depressive Type.”

According to the DSM-IV-TR, the diagnostic criteria for a Schizoaffective Disorder are as follows:

A. An uninterrupted period of a non-specified duration during which there has been either a Major Depressive Episode, a Manic Episode or a Mixed Episode as well as the signs and/or symptoms of Schizophrenia, as defined by Criterion A for that disorder.

B. During that same time period there have been delusions or hallucinations that have lasted at least two weeks, but there have been no prominent mood signs and/or symptoms.

C. The signs and/or symptoms of the Mood Episode have been present for a substantial portion of the total time the individual has had the disorder.

D. The signs and/or symptoms are not due to the direct physiological effects of a substance and/or a general medical condition.
VII. Sleep Disorders

The DSM-IV-TR describes four classes of sleep disorders and categorizes them by their cause. The four classes are: Primary Sleep Disorders, Sleep Disorders Related to Another Mental Disorder, Sleep Disorders Due to a General Medical Condition and Substance-Induced Sleep Disorders.

Primary Sleep Disorders involve disturbances of sleep that are not due to another mental disorder, a general medical condition or a substance. Primary Sleep Disorders are classified as either Dyssomnias, in which the person exhibits abnormalities in the amount, quality or timing of sleep, or Parasomnias, in which they show abnormal behaviors and/or physiological events during sleep. As the name implies, Sleep Disorders Related to Another Mental Disorder involve disturbances of sleep that result from another mental disorder. Similarly, Sleep Disorders Due to a General Medical Condition involve disturbances of sleep due to the direct physiological effects of a general medical condition. Substance-Induced Sleep Disorders involve sleep disturbances that are attributable to the current or recent use of a substance.

1. Primary Sleep Disorders

As previously noted at the beginning of this section, Primary Sleep Disorders are classified as Dyssomnias, which are characterized by abnormalities in the amount, quality or timing of sleep, and, Parasomnias, which are characterized by abnormal behaviors and/or physiological events that occur during sleep.

a) Dyssomnias

(1) Primary Insomnia (307.42)

Primary Insomnia is a disorder in which the person exhibits difficulty in initiating and/or in maintaining sleep and/or experiencing nonrestorative sleep. In order to diagnose this condition correctly the signs and/or symptoms must have been present for one month or
longer. The DSM-IV-TR diagnostic criteria for Primary Insomnia are given below.

A. The principal complaint is difficulty initiating and/or maintaining sleep and/or having nonrestorative sleep that has been present for at least a month.
B. The insomnia and/or the fatigue it produces cause clinically significant distress and/or impairment in social and/or occupational and/or some other important area of functioning.
C. The insomnia does not occur exclusively during the course of Narcolepsy, Breathing-Related Sleep Disorder, Circadian Rhythm Sleep Disorder or a Parasomnia, all of which are discussed below.
D. The insomnia does not occur exclusively during the course of another sleep disorder.
E. The insomnia is not due to the direct physiological effects of a substance and/or a general medical condition.

(2) Primary Hypersomnia (307.44)

Primary Hypersomnia is a disorder that is characterized by excessive sleepiness as shown by prolonged sleep episodes and/or by daytime sleeping episodes that have been occurring daily or almost daily for at least a month. The DSM-IV-TR diagnostic criteria for Primary Hypersomnia are given below.

A. The individual’s primary complaint is excessive sleepiness as shown by prolonged sleep episodes and/or by daytime sleeping episodes that have been occurring daily or almost daily for at least a month.
B. The excessive sleepiness has caused clinically significant distress and/or impairment in social and/or occupational and/or some other important area of functioning.
C. The excessive sleepiness cannot be reasonably attributed to insomnia and/or an inadequate amount of sleep and is not due to another sleep disorder.
D. The excessive sleepiness does not occur exclusively during the course of another mental disorder.
E. The excessive sleepiness is not due to the direct physiological effects of a substance and/or a general medical condition.

(3) **Narcolepsy (347)**

According to the DSM-IV-TR, the main component of Narcolepsy is the occurrence of irresistible episodes of refreshing sleep that have occurred daily over a period of at least three months. The DSM-IV-TR diagnostic criteria for Narcolepsy are given below.

A. Irresistible episodes of refreshing sleep that have occurred daily over a period of at least three months.
B. The presence of (1) or (2), below.
   (1) Cataplexy or brief episodes of bilateral loss of muscle tone leading to collapse and/or immobility that last for a few seconds to a few minutes.
   (2) The occurrence of repeated episodes of elements of REM (rapid eye movement) sleep into the transition between the sleeping and waking state. This is observed as intense or vivid dreamlike imagery just before falling asleep (hypnagogic hallucinations) or just after waking up (hypnopompic hallucinations). Alternately, sleep paralysis, in which the individual is awake but unable to move or speak, can independently satisfy this criterion.
C. The narcoleptic episodes are not due to the direct physiological effects of a substance and/or a general medical condition.

(4) **Breathing-Related Sleep Disorder (780.59)**

According to the DSM-IV-TR, the main component of a Breathing-Related Sleep Disorder is a disruption of sleep that leads to excessive sleepiness and/or insomnia that is the result of abnormal breathing during sleep. The DSM-IV-TR diagnostic criteria for a Breathing-Related Sleep Disorder are given below.
A. A disruption of sleep that leads to excessive sleepiness and/or insomnia that is due to a sleep-related breathing condition such as an Obstructive Sleep Apnea Syndrome.

B. The sleep disturbance is not better accounted for by another mental disorder and is not due to the direct physiological effects of a substance and/or a general medical condition other than a breathing-related disorder.

(5) Circadian Rhythm Sleep Disorder (307.45)

According to the DSM-IV-TR, the main component of a Circadian Rhythm Sleep Disorder is a persistent and/or recurrent disruption of sleep that occurs as a result of a discrepancy between an individual’s endogenous circadian sleep-wake pattern and the exogenous demands on the individual relating to the time and duration of their sleep. In more simple terms, there is a mismatch between the individual’s normal sleep pattern and the demands of their environment that leads to a persistent and/or recurrent disruption of sleep. The DSM-IV-TR diagnostic criteria for a Circadian Rhythm Sleep Disorder are given below.

A. The individual must show a persistent and/or recurrent disruption of sleep that occurs as a result of a discrepancy between an individual’s endogenous or normal circadian sleep-wake pattern and the exogenous or external demands on the individual relating to the time and duration of their sleep.

B. The sleep disturbance must cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

C. The sleep disturbance does not occur exclusively in the course of another sleep or mental disorder.

D. The disturbance is not due to the direct physiological effects of a substance and/or a general medical condition.
b) Parasomnias

(1) Nightmare Disorder (307.47)

According to the DSM-IV-TR, the main component of a Nightmare Disorder is the repetitious awakening from sleep as a result of frightening dreams. The DSM-IV-TR diagnostic criteria for a Nightmare Disorder are given below.

A. The individual repeatedly awakens from sleep as a result of having frightening nightmares.
B. When awakening from a frightening nightmare the individual rapidly becomes oriented and alert.
C. The dream experience and/or the disturbance of sleep that results from the awakening must cause clinically significant distress and/or impairment in social, occupations and/or other important areas of functioning.
D. The frightening nightmares do not occur solely as part of another mental disorder and are not due to the direct physiological effects of a substance and/or a general medical condition.

(2) Sleep Terror Disorder (307.46)

According to the DSM-IV-TR, the main component of a Sleep Terror Disorder is the repetitious awakening from sleep with a “panicky scream” or cry. The DSM-IV-TR diagnostic criteria for a Sleep Terror Disorder are given below.

A. There must be recurrent episodes in which, usually during the first third of a major sleep episode, the individual abruptly awakens from sleep with a “panicky scream.”
B. During each episode the individual shows intense fear with signs of autonomic arousal such as a rapid heartbeat, rapid breathing and/or sweating.
C. During an episode the individual is relatively unresponsive to the efforts of others to provide comfort.
D. The episodes cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.
E. The disturbance is not due to the direct physiological effects of a substance and/or a general medical condition.

(3) **Sleepwalking Disorder (307.46)**

According to the DSM-IV-TR, a Sleepwalking Disorder is diagnosed correctly when the individual presents with repeated episodes of complex motor behaviors that begin during sleep and include getting up from their bed and walking about. The DSM-IV-TR diagnostic criteria for a Sleepwalking Disorder are given below.

A. The individual presents with repeated episodes of getting up from bed during sleep and walking about, usually during the first third of a major sleep episode.
B. During sleepwalking episodes the person can be observed to have a blank, staring face and is relatively unresponsive to communications and is very difficult to awaken.
C. On awakening after an episode the individual has no recollection of sleepwalking.
D. Shortly after awakening from a sleepwalking episode there may be a brief period of time in which the person is confused and/or disoriented although within several minutes there is no observable impairment in mental activity or behavior.
E. The sleepwalking causes clinically significant distress and/or impairment in social, occupational and/or other import areas of functioning.
F. The sleepwalking is not due to the direct physiological effects of a substance and/or a general medical condition.

2. **Sleep Disorders Related to Another Mental Disorder**

According to the DSM-IV-TR, there are two sleep disorders that are related to another mental disorder. They are: Insomnia Related
to Another Mental Disorder (307.42) and Hypersomnia Related to Another Mental Disorder (307.44).

a) **Insomnia Related to Another Mental Disorder (307.42)**

According to the DSM-IV-TR, Insomnia Related to Another Mental Disorder is diagnosed correctly when the individual presents with evidence of insomnia that is related to or due to another mental disorder. The specific DSM-IV-TR diagnostic criteria for Insomnia Related to Another Mental Disorder are given below.

A. The individual’s principal complaint is that they have had difficulty initiating or maintaining sleep, or have had nonrestorative sleep, for at least a month and that this sleep problem has been associated with daytime fatigue and/or impaired daytime functioning.
B. The insomnia, and/or the daytime effects of the disturbance, causes clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.
C. The insomnia is judged to be related to or caused by another Axis I disorder or an Axis II disorder.
D. The insomnia is not better accounted for by another DSM-IV-TR sleep disorder.
E. The disturbance is not due to the direct physiological effects of a substance and/or a general medical condition.

Additionally, it is important to note that the name of this disorder actually incorporates the name of the Axis I or Axis II disorder. For example, if the insomnia is due to an Adjustment Disorder With Depressed Mood then the sleep disorder is diagnosed as: Insomnia Related to an Adjustment Disorder With Depressed Mood (307.42).

b) **Hypersomnia Related to Another Mental Disorder (307.44)**

According to the DSM-IV-TR, Hypersomnia Related to Another Mental Disorder is diagnosed correctly when the individual presents with evidence of excessive sleepiness that is related to or due to
another mental disorder. The specific DSM-IV-TR diagnostic criteria for Insomnia Related to Another Mental Disorder are given below.

A. The individual’s principal complaint is excessive sleepiness for at least a month that is characterized by prolonged sleep episodes and/or daytime sleep episodes that occur almost daily.
B. The signs and/or symptoms of excessive sleepiness have caused clinically significant distress and/or impairment in social, occupational and/or other areas of functioning.
C. The sleepiness or hypersomnia is judged to be related or caused by another Axis I disorder or an Axis II disorder.
D. The sleepiness or hypersomnia is not better accounted for by another DSM-IV-TR sleep disorder.
E. The disturbance is not due to the direct physiological effects of a substance and/or a general medical condition.

Once again, it is important to note that the name of this disorder actually incorporates the name of the Axis I or Axis II disorder. For example, if the sleepiness or hypersomnia is due to an Adjustment Disorder With Depressed Mood then the sleep disorder is diagnosed as: Hypersomnia Related to an Adjustment Disorder With Depressed Mood (307.44).

3. Sleep Disorders Due to a General Medical Condition (780.xx)

According to the DSM-IV-TR, a Sleep Disorder Due to a General Medical Condition (780.xx) is characterized by a prominent disturbance in sleep that is both sufficiently severe to warrant independent clinical attention and is due to a general medical condition. There are four subtypes of a Sleep Disorder Due to a General Medical Condition. These are: the Insomnia Type (780.52), the Hypersomnia Type (780.54), the Parasomnia Type (780.59) and the Mixed Type (780.59). As you can see, the four Sleep Disorders Due to a General Medical Condition are denoted with a numerical diagnostic code beginning with “780.” The “xx” in the parentheses above indicates that it is up to the diagnosing practitioner to determine which of the four categories is present and then to use the appropriate verbal descriptions of the disorders and provide the
appropriate numerical diagnostic codes. The diagnosing practitioner also must specify the general medical condition that is present by providing the name of that condition in the verbal designation of the disorder. For example, they may diagnose a Sleep Disorder Due to Rheumatoid Arthritis, Insomnia Type (780.52). A further description of these four types of sleep disorders is discussed below under the category of Mental Disorders Due to a General Medical Condition. The interested reader is referred to that section for a complete discussion of these disorders.

4. Substance-Induced Sleep Disorders (291.xx or 292.xx)

According to the DSM-IV-TR, a Substance-Induced Sleep Disorder is diagnosed correctly when there is a prominent disturbance in sleep that is due to the direct physiological effects of a substance such as a drug of abuse, a medication or a toxin. The diagnostic criteria for Substance-Induced Sleep Disorders are given below.

A. There must be a prominent disturbance in sleep that is of sufficient severity to warrant independent clinical attention in the form of diagnosis and treatment.
B. There are data from the patient’s history, a physician’s physical examination and/or laboratory findings of at least one of the following:
   (1) A prominent disturbance of sleep that developed during or within a month of substance intoxication or substance withdrawal.
   (2) A prominent disturbance of sleep that has been caused by the medication.
C. There are data indicating that the prominent disturbance in sleep has not been caused by another DSM-IV-TR Sleep Disorder.
D. The prominent disturbance in sleep has not occurred during an episode of delirium.
E. The sleep disturbance causes clinical significant distress and/or impairment in social, occupational and/or other important areas of functioning.
F. In the case of the sleep disturbance being due to substance intoxication or substance withdrawal, there are data indicating that the sleep disturbance is in excess of what would normally be caused by intoxication or withdrawal, and despite the existence of substance intoxication or withdrawal the disturbance requires independent clinical attention.

Further, it is important to note that the name of this disorder actually incorporates the name of the substance that has induced the sleep disorder and requires that the doctor further specify the nature of the disorder by noting if the sleep disturbance is of the Insomnia Type, the Hypersomnia Type, the Parasomnia Type or the Mixed Type. In the case of the latter, more than one sleep disturbance type is present but none is predominant. Additionally, the doctor can specify if the disorder had its onset with intoxication or during withdrawal. For example, one such diagnosis is an Alcohol-Induced Sleep Disorder, Insomnia Type, With Onset During Withdrawal (291.8). A full discussion of the specific verbal descriptions of the various disorders and their numerical codes, which all begin with either 291 or 292, is found on page 656 of the DSM-IV-TR and is beyond the scope of this text.

VIII. Somatoform Disorders

The Somatoform Disorders are characterized by the presence of physical signs and/or symptoms that suggest that the individual has a general medical condition accounting for the signs and/or symptoms but those signs and/or symptoms cannot be fully explained by a general medical condition, the direct effects of a substance or another mental disorder. Essentially, the person presents with medically unexplained physical signs and/or symptoms and there is reason to suspect that their complaints are due to psychological factors or variables and that the individual is not faking or Malingering (V65.2). The most frequently diagnosed Somatoform Disorders are: a Somatization Disorder, an Undifferentiated Somatoform Disorder, a Conversion Disorder, Pain Disorders, and Hypochondriasis.
1. Somatization Disorder (300.81)

According to the DSM-IV-TR, in order to diagnose a Somatization Disorder (300.81) correctly the individual must present with multiple physical symptoms or complaints that cannot be fully explained by the presence of a known general medical condition or the direct effects of a substance. The individual must also present with a pattern of recurring, multiple and clinically significant physical complaints that began before the age of 30 and have occurred over a period of several years. In general, Somatization is said to exist when an individual presents with complaints that appear to be indicative of a general medical condition but that, after clinical investigation by the appropriate medical practitioners, no medical condition is found to explain the patient’s complaints. The specific DSM-IV-TR diagnostic criteria for a Somatization Disorder (300.81) are given below.

A. The individual must present with a history of multiple physical complaints that began before the age of 30 and have occurred over a period of several years and have resulted in their seeking treatment and/or significant impairment in social, occupational and/or other important areas of functioning.

B. There must be a history of multiple complaints occurring at some time in the person’s past in each of the areas given below.

   (1) Four pain complaints: A history of pain related to at least four different physiological sites or functions, such as the head or back or during menstruation or urination.

   (2) Two gastrointestinal complaints: A history of at least two gastrointestinal complaints other than pain such as nausea, bloating or food intolerance.

   (3) One sexual complaint: A history of at least one sexual or reproductive complaint other than pain, for example, sexual indifference or erectile dysfunction.

   (4) One pseudoneurological symptom: A history of at least one complaint and/or deficit suggesting a non-pain neurological disorder as shown by impaired
coordination or balance or a loss of the sensation of touch.
C. After appropriate medical evaluation the complaints in Criterion B cannot be fully explained by known underlying organic pathology or the direct effects of a substance, or when there is an underlying general medical condition the complaints and/or the social and/or occupation impairments are in excess of what one would expect from the history and medical evaluations.
D. The complaints are not intentionally produced.

2. Undifferentiated Somatoform Disorder (300.81)

A reading of the DSM-IV-TR indicates that an Undifferentiated Somatoform Disorder (300.81) is diagnosed correctly when the individual presents with one or more physical complaints that have been present for at least six months. Additionally, after appropriate medical evaluation, either those complaints cannot be fully explained by a known general medical condition or the complaints are in excess of what would be expected from the patient’s history, physical examination and laboratory findings. The specific DSM-IV-TR criteria are presented below.

A. The individual must present with one or more physical complaints such as fatigue, a loss of appetite or urinary symptoms.
B. After appropriate medical evaluations the complaints cannot be fully explained by an underlying medical disorder or the direct effects of a substance, or when there is an underlying medical disorder, the complaints and resulting impairments in social and/or occupational functioning are in excess of what one would expect judging by the patient’s history and medical evaluations.
C. The complaints must cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.
D. The complaint must have been present for at least six months.
E. The disturbance is not better accounted for by another DSM-IV-TR disorder.
F. The complaints are not intentionally produced.

3. Conversion Disorder (300.11)

As described in the DSM-IV-TR, the essential feature of a Conversion Disorder (300.11) is the presence of signs and/or symptoms and/or deficits that effect voluntary motor and/or sensory function that appear to be indicative of a neurological or other general medical condition but that cannot be explained by appropriate medical evaluation to be due to non-psychological medical causes. For example, an individual may present with a motor sign and/or symptom, such as a paralysis or a localized weakness, or sensory signs and/or symptoms, such as the loss of touch or pain sensations. However, medical evaluation reveals no known physical pathology that can completely account for the patient’s complaints. Moreover, the psychological evaluation reveals a likelihood that the signs and/or symptoms are due to some psychosocial event such as a conflict or other stressors in the individual’s environment. The specific diagnostic criteria for a Conversion Disorder are given below.

A. There must be one or more signs and/or symptoms and/or deficits that affect voluntary motor and/or sensory function, suggesting a neurological or other general medical condition.
B. Psychological factors or variables are judged to be the cause of the disturbance because the onset or aggravation of the signs and/or symptoms and/or the deficits was preceded by conflicts and/or other psychosocial stressors.
C. The signs and/or symptoms and/or the deficits have not been intentionally produced.
D. The signs and/or symptoms and/or the deficits cannot be fully explained, by appropriate medical specialists who have evaluated the patient, as being due to a non-psychiatric medical condition, the direct effects of a substance or a “culturally sanctioned behavior or experience.”
E. The signs and/or symptoms and/or the deficits must cause significant impairment and/or distress in social, occupational and/or other important areas of function or must warrant non-psychiatric medical evaluation.

F. The signs and/or symptoms and/or the deficits are not limited to pain or sexual dysfunction and are not better accounted for by another mental disorder.

4. Pain Disorders

An inspection of the DSM-IV-TR reveals that it delineates two different Pain Disorders that are due to psychological factors or variables. These are called a Pain Disorder Associated With Psychological Factors (307.80) and a Pain Disorder Associated With Both Psychological Factors and a General Medical Condition (307.89). In general, these disorders are diagnosed correctly when there is pain in one or more anatomical sites that is sufficiently severe to warrant clinical attention and is the predominant focus of the individual’s clinical presentation. In order to diagnose this condition correctly the pain must also cause significant distress and/or impairment in social, occupational and/or other important areas of functioning and psychological factors have been shown to have an important role in the onset, severity, exacerbation and/or maintenance of the pain. Additionally, it must be shown that the pain cannot be completely explained by non-psychological factors. Moreover, the symptoms must not be intentionally produced and the pain is not better accounted for by another DSM-IV-TR disorder.

a) Pain Disorder Associated With Psychological Factors (307.80)

An inspection of the DSM-IV-TR reveals that a Pain Disorder Associated With Psychological Factors (307.80) is diagnosed correctly when psychological factors are judged to have the major role in the onset, severity, exacerbation or maintenance of an individual’s pain. In this disorder there must be evidence indicating that general medical conditions either play no role in the onset or the maintenance of the pain, or play a “minimal role” in the pain’s onset and maintenance. In order to diagnose this disorder correctly the
pain must cause significant distress and/or impairment in social, occupational and/or other important areas of functioning and there must be evidence that the signs and/or symptoms are not intentionally produced or feigned. Additionally, a crucial factor in determining if there is a Pain Disorder Associated With Psychological Factors is the presence of data from specialists in disciplines such as orthopedics, neurology or internal medicine who have found evidence that the patient’s complaints of pain cannot be completely understood by the underlying physical pathology or by attempts at an exaggeration and/or simulation of symptoms.

b) Pain Disorder Associated With Both Psychological Factors and a General Medical Condition (307.89)

According to the DSM-IV-TR, in order to diagnose a Pain Disorder Associated With Both Psychological Factors and a General Medical Condition correctly, it is necessary to demonstrate that both psychological factors and a general medical condition have important roles in the onset, severity, exacerbation and/or maintenance of the pain. In this regard, a Pain Disorder Associated With Both Psychological Factors and a General Medical Condition is diagnosed when specialists in disciplines such as orthopedics, neurology or internal medicine have found evidence that not all of the patient’s complaints of pain can be completely understood by the underlying physical pathology or attempts at an exaggeration and/or simulation of symptoms.

c) Pain Disorder Associated With a General Medical Condition

The DSM-IV-TR is very clear in stating on page 499 that a Pain Disorder Associated With a General Medical Condition is a disorder in which there is pain that results from a general medical condition. The DSM-IV-TR is also very explicit in stating, “This subtype of Pain Disorder is not considered a mental disorder and is coded on Axis III.” Accordingly, if one is concerned with the possibility of an individual having had a psychological disorder, the specification of a Pain Disorder Associated With a General Medical Condition is clearly not relevant since this condition is not a mental disorder.
5. **Hypochondriasis (300.7)**

According to the DSM-IV-TR, the essential feature of Hypochondriasis (300.7) is the patient’s preoccupation with a fear of a serious medical illness that is based entirely on the individual’s misinterpretation of one or more bodily signs and/or symptoms. Typically, no amount of medical evaluation and/or reassurance from the appropriate professional specialists can allay the person’s concern about having the illness. The DSM-IV-TR diagnostic criteria are given below.

A. A preoccupation with fears of having a serious medical illness that is based on the individual’s misinterpretation of bodily signs and/or symptoms.
B. The individual’s preoccupation with their fears continues despite medical evaluation and/or assurance from appropriate professional specialists.
C. The preoccupation is not delusional or restricted to an unrealistic concern or an imaginary defect in one’s appearance.
D. The preoccupation has caused some clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.
E. The disturbance must have been present for at least six months.
F. The preoccupation is not better accounted for by another DSM-IV-TR disorder such as an Obsessive-Compulsive Disorder, among others.

**IX. Mental Disorders Due to a General Medical Condition**

Disorders Due to a General Medical Condition are characterized by signs and/or symptoms of a psychological nature that are due to the direct physiological consequences of a general medical condition. There are many general medical conditions that can directly produce a mental disorder such as central nervous system neoplasms, head traumas, cerebrovascular diseases, epilepsy, human immunodeficiency viruses, endocrine conditions, and lupus. As noted above, the hallmark of these conditions is that
they are directly produced by the physical disorder through a physiological mechanism and are therefore not the result of the individual simply becoming psychologically symptomatic because of their knowledge of being ill.

The most frequently diagnosed Disorders Due to a General Medical Condition are: an Anxiety Disorder Due to a General Medical Condition (293.89), a Mood Disorder Due to a General Medical Condition (293.83), a Personality Change Due to a General Medical Condition (310.1), Sleep Disorders Due to a General Medical Condition, Dementia Due to Head Trauma (294.10), Dementia Due to Other General Medical Conditions (284.1), a Mental Disorder Not Otherwise Specified Due to a General Medical Condition (293.9), Male Hypoactive Sexual Desire Disorder Due to a General Medical Condition (308.89) and Female Hypoactive Sexual Desire Disorder Due to a General Medical Condition (625.8).

1. **Anxiety Disorder Due to a General Medical Condition (293.89)**

   According to the DSM-IV-TR, an Anxiety Disorder Due to a General Medical Condition (293.89) is diagnosed correctly when the individual presents with clinically significant anxiety that is judged to be due to the direct physiological effects of a general medical condition. In this regard, the DSM-IV-TR is very explicit in stating that there must be evidence from the patient’s history, physical examination or laboratory findings to indicate that the anxiety is due to the direct physiological consequence of a general medical condition. The anxiety also must cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

   The DSM-IV-TR goes on to indicate that the general medical conditions that can cause anxiety symptoms include endocrine conditions such as hyperthyroidism, hypothyroidism, pheochromocytoma (a neurological tumor most common to the adrenal medulla), hypoglycemia and hyperadrenocorticism (an abnormal increase in activity of the adrenal gland), cardiovascular conditions such as congestive heart failure, pulmonary embolisms and arrhythmia, respiratory conditions such as chronic obstructive
pulmonary disease, pneumonia and hyperventilation, metabolic conditions such as vitamin B12 deficiency and porphyria (a genetically produced metabolic disorder), and neurological conditions such as neoplasms, vestibular dysfunctions and encephalitis. If there are inadequate data to demonstrate that the individual has a general medical condition that is known to produce anxiety-like symptoms through the effect of that general medical condition, it is incorrect to diagnose an Anxiety Disorder Due to a General Medical Condition.

Additionally, while an Anxiety Disorder Due to a General Medical Condition appears in the DSM-IV-TR, it can be said that since the cause of this condition is a known general medical condition, the signs and/or symptoms of this disorder are not indicative of a psychological or mental disorder but simply the signs and/or symptoms of the underlying general medical condition.

2. Mood Disorder Due to a General Medical Condition (293.83)

According to the DSM-IV-TR, the essential feature of a Mood Disorder Due to a General Medical Condition (293.83) is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. The mood disturbance may involve a depressed mood; a markedly diminished interest or pleasure; or an elevated, expansive or irritable mood. In addition, there must be evidence from the history, physical examination, or laboratory findings to indicate that the disturbance is due to the direct physiological consequence of a general medical condition. The mood disturbance also must cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning. Moreover, there must be a general medical condition and it must be established that the mood disturbance is causally related to the general medical condition through a physiological mechanism.

A variety of general medical conditions may cause mood symptoms. These conditions are specified in the DSM-IV-TR as degenerative neurological conditions, cerebrovascular disease, metabolic conditions, endocrine conditions, autoimmune conditions, viral or other infections, and certain cancers. A reading of page 403
of the DSM-IV-TR, where the medical disorders causing a Mood Disorder Due to a General Medical Condition are listed, reveals no evidence indicating that such a disorder can be produced by orthopedic or any general medical conditions not listed above, nor is there anything in the psychological or psychiatric literature indicating that a Mood Disorder can be produced by any such conditions.

Additionally, while a Mood Disorder Due to a General Medical Condition appears in the DSM-IV-TR it can be said that since the cause of this condition is a known general medical condition, the signs and/or symptoms of this disorder are not indicative of a psychological or mental disorder, but simply the signs and/or symptoms of the underlying general medical condition.

3. Personality Change Due to a General Medical Condition (310.1)

According to the DSM-IV-TR, the essential feature of a Personality Change Due to a General Medical Condition (310.1) is a persistent personality disturbance that is judged to be due to the direct physiological effects of a general medical condition. The individual may present with a variety of personality disturbances but the disturbance represents a change from the individual’s previous characteristic personality pattern. There also must be evidence from the history, physical examination, or laboratory findings that the disturbance is due to the direct physiological consequence of a general medical condition. Additionally, the disturbance is not better accounted for by another mental disorder, does not occur exclusively during the course of a delirium, does not meet the criteria for a dementia, and causes clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

Further, while a Personality Change Due to a General Medical Condition appears in the DSM-IV-TR it can be said that since the cause of this condition is a known general medical condition, the signs and/or symptoms of this disorder are not indicative of a psychological or mental disorder, but simply the signs and/or symptoms of the underlying general medical condition.
4. Sleep Disorders Due to a General Medical Condition

According to the DSM-IV-TR, a Sleep Disorder Due to a General Medical Condition (780.xx) is characterized by a prominent disturbance in sleep that is severe enough to warrant independent clinical attention and is due to a general medical condition. In addition, there must be evidence from the history, physical examination, or laboratory findings that the sleep disturbance is due to the direct physiological consequence of a general medical condition. Furthermore, the sleep symptoms must cause clinically significant distress and/or impairment in social, occupational, and/or other important areas of functioning and must not be caused by another mental disorder.

The general medical conditions that can cause sleep disturbances include, but are not limited to, degenerative neurological illnesses such as Parkinson’s disease and Huntington’s disease; cerebrovascular disease such as vascular lesions in the upper brain stem; endocrine conditions such as hypothyroidism and hyperthyroidism; viral and bacterial infections such as viral encephalitis; coughing related to pulmonary disease such as bronchitis; and pain from musculoskeletal disease such as rheumatoid arthritis and fibromyalgia; myotonic dystrophy and Prader-Willi syndrome.

There are four subtypes of a Sleep Disorder Due to a General Medical Condition. There is the Insomnia Type (780.52), in which the predominant sleep disturbance is insomnia. In the Insomnia Type, the primary complaint is difficulty falling asleep, difficulty maintaining sleep or a feeling of non-restorative sleep. There is the Hypersomnia Type (780.54), in which the predominant sleep disturbance is hypersomnia or excessive sleep. There is Parasomnia Type (780.59), in which there may be a variety of abnormal behaviors or physiological events occurring during sleep, or sleep-wake transitions such as sleepwalking, teeth grinding, night terrors, rhythmic movement disorder, REM behavior disorder and restless legs syndrome. And finally, there is Mixed Type (780.59), in which there is more than one sleep disturbance present. While all of these disorders appear in the DSM-IV-TR, it can be said that since the cause of these conditions is a known general medical condition, the
signs and/or symptoms of these disorders are not indicative of a psychological or mental disorder but simply the signs and/or symptoms of the underlying general medical condition.

Additionally, it is important to note that the name of this disorder actually incorporates the name of the general medical condition causing the sleep disorder. For example, if the insomnia is due to pain from rheumatoid arthritis then the sleep disorder is diagnosed as a Sleep Disorder Due to Rheumatoid Arthritis, Insomnia Type (780.52). An additional discussion of Sleep Disorders Due to a General Medical Condition can be found above in Chapter 3.

5. Dementia Due to Head Trauma (294.1)

According to the DSM-IV-TR, Dementia Due to Head Trauma (294.1) is defined as the presence of dementia that is judged to be due to the direct pathophysiological consequence of a head trauma.

In this regard, an inspection of the DSM-IV-TR indicates that dementia is characterized by the development of multiple cognitive deficits, including memory impairments, and at least one of the cognitive disturbances of aphasia, apraxia, agnosia, or a disturbance in executive functioning, discussed below. In addition, the deficits must be sufficiently severe to cause impairment in occupational and/or social functioning and must represent a decline from a previously higher level of functioning. In advanced stages of dementia, memory impairments are associated with the person forgetting their occupation, schooling, birthday, family members, and sometimes even their own name.

Aphasia is a deterioration of language functioning, where an individual is said to have difficulty producing the names of individuals and objects. The speech of individuals with aphasia may become vague or empty, with long circumlocutory phases and excessive use of terms of indefinite references, such as “thing” and “it.” Apraxia is the impaired ability to execute motor activity although there is no paralysis or other motor or sensory impairment and the person understands the task’s requirements. Individuals with apraxia are impaired in their ability to perform tasks such as combing hair or
waving goodbye. Agnosia is the failure to recognize or identify objects despite intact sensory function. Executive functioning involves the ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior. Individuals with deficits in this area may have difficulty coping with novel tasks and may avoid situations that require the processing of new and complex information. Clearly, in order to diagnose Dementia Due to Head Trauma there must be a history of head trauma and reason to suspect that the dementia that followed is due to the direct pathophysiological consequence of the trauma and not some other cause.

With regard to the relevance of Dementia Due to Head Trauma to the litigation process, it should be noted that this diagnosis completely overlaps comparable diagnoses that would be made by a neurologist who would be the most appropriate and qualified specialist to diagnose a neurological condition. Thus, what is quite clear is that the diagnosis of Dementia Due to Head Trauma is essentially not indicative of a psychological injury if a neurologist is considering the dementia as being part of a neurological injury. To consider Dementia Due to Head Trauma to be indicative of a psychological injury as well as a neurological injury would be to support a double recovery for a single set of impairments.

6. Dementia Due to Other General Medical Conditions (294.1)

As noted above, the diagnosis of Dementia Due to Head Trauma, is a condition that is somewhat frequently found in the litigation of psychological injuries. However, it is important to note that this diagnosis is a special case of Dementia Due to Other General Medical Conditions (294.1). More specifically, the DSM-IV-TR outlines many other conditions that can produce dementia that may be relevant to any given case. To name just a few, HIV Disease, Parkinson’s Disease, Huntington’s Disease and Pick’s Disease can produce dementia. Clearly, the source of an individual’s dementia must be carefully considered by a neurologist, and one cannot simply assume that the disorder was produced by a head trauma simply because such a trauma is found in the person’s history. Additionally, although this disorder appears in the DSM-IV-TR it can be said that
since the cause of this condition is a known general medical condition, the signs and/or symptoms of this disorder are not indicative of a psychological or mental disorder, but simply the signs and/or symptoms of the underlying general medical condition.

7. Sexual Dysfunction Due to a General Medical Condition

Sexual Dysfunction Due to a General Medical Condition is not a disorder itself but a class of disorders in which there is a clinically significant sexual dysfunction that is due solely to the direct physiological effects of a general medical condition. Experience has shown that the two most frequently found disorders in this class are Male Hypoactive Sexual Desire Disorder Due to a General Medical Condition (308.89) and Female Hypoactive Sexual Desire Disorder Due to a General Medical Condition (625.8).

a) Male Hypoactive Sexual Desire Disorder Due to a General Medical Condition (608.89) and Female Hypoactive Sexual Desire Disorder Due to a General Medical Condition (625.8)

According to the DSM-IV-TR, in order to diagnose correctly either Male Hypoactive Sexual Desire Disorder Due to a General Medical Condition (608.89) or Female Hypoactive Sexual Desire Disorder Due to a General Medical Condition (625.8) it is necessary to show that there is a deficit or absence of sexual fantasies as well as a lack of a desire for sexual activity that is judged to be entirely due to the direct physiological effects of a general medical condition. As such, there must be evidence from the history, physical examination or laboratory findings that the dysfunction is fully explained by the direct physiological effects of an existing general medical condition. As specified in the DSM-IV-TR, there are a variety of neurological, endocrine, vascular, and genitourinary conditions such as multiple sclerosis, diabetes mellitus and urethral infections that can produce sexual dysfunction in this manner. However, simply not wanting to engage in intercourse or other sexual behavior because of pain or some other physical condition does not meet the DSM-IV-TR criteria for establishing that there is dysfunction as a result of a direct physiological mechanism. Additionally, in specifying
this disorder, the practitioner must specify the name of the general condition by stating, for example, Female Hypoactive Sexual Desire Disorder Due to Diabetes Mellitus (625.8). Finally, although these disorders appear in the DSM-IV-TR, it can be said that since the cause of these conditions is a known general medical condition, the signs and/or symptoms of these disorders are not indicative of a psychological or mental disorder, but simply the signs and/or symptoms of the underlying general medical condition.

8. Mental Disorder Not Otherwise Specified Due to a General Medical Condition (293.9)

According to the DSM-IV-TR, a Mental Disorder Not Otherwise Specified Due to a General Medical Condition (293.9) is a residual category used for situations in which it has been established that there is a mental disorder that has been caused by the direct physiological effects of a general medical condition, but the criteria are not met for a specific Mental Disorder Due to a General Medical Condition. That is, the individual does not qualify for any of the following diagnoses: an Anxiety Disorder Due to a General Medical Condition (293.89), a Mood Disorder Due to a General Medical Condition (293.83), a Personality Change Due to a General Medical Condition (310.1), Sleep Disorders Due to a General Medical Condition, Dementia Due to Head Trauma (294.10), Dementia Due to Other General Medical Conditions (294.1), Male Hypoactive Sexual Desire Disorder Due to a General Medical Condition (308.89) and Female Hypoactive Sexual Desire Disorder Due to a General Medical Condition (625.8). The interested reader is referred elsewhere in this text where these disorders are discussed. Finally, once again, although these disorders appear in the DSM-IV-TR it can be said that since the cause of these conditions is a known general medical condition, the signs and/or symptoms of these disorders are not indicative of a psychological or mental disorder, but simply the signs and/or symptoms of the underlying general medical condition.

X. Eating Disorders
Quite simply, the Eating Disorders are characterized by a severe disturbance in eating behavior. In the DSM-IV-TR there are only two major adult eating disorders: Anorexia Nervosa (307.1) and Bulimia Nervosa (307.51). It is important to note that while obesity is a general medical condition discussed in the *International Classification of Diseases, Ninth Revision, Clinical Modification*, and many individuals consider obesity both a national health problem and a mental disorder, it is not defined as a disorder in the DSM-IV-TR. Nevertheless, the DSM-IV-TR recognizes that psychological factors or variables may influence obesity and may be considered to be a condition that becomes a focus of clinical attention. These conditions are discussed below in Section XIV under the title of “Conditions That May Be a Focus of Interest.”

1. Anorexia Nervosa (307.1)

The DSM-IV-TR is very clear in specifying that in order to diagnose Anorexia Nervosa (307.1) correctly the individual must refuse to maintain a minimally normal body weight, is intensely frightened of gaining weight and shows a significant disturbance in their perception of the size and/or shape of their body. The specific diagnostic criteria are given below.

A. A refusal to maintain a body weight at or above 85% of the norm for their gender and age, or the failure to gain weight during a period of growth to maintain that norm.
B. An intense fear of gaining weight and/or becoming fat despite the fact that the person may be underweight.
C. A disturbance in the way one perceives their body weight and/or shape, an undue influence of body weight and/or shape on one’s self-evaluation, and/or a denial of the seriousness of an existing low body weight.
D. Amenorrhea in postmenarcheal females, as defined by the absence of at least three consecutive menstrual cycles.

In addition to the above, the diagnosing practitioner must specify if they believe the individual’s Anorexia Nervosa is the Restricting Type or the Binge-Eating/Purging Type. In the Restricting Type the individual does not engage in binge eating or purging, but
keeps their weight down by restricting caloric intake. In the Binge-Eating/Purging Type the individual regularly engages in purging behavior by, for example, self-induced vomiting, or the misuse of laxatives, diuretics and/or enemas.

2. **Bulimia Nervosa (307.51)**

According to the DSM-IV-TR, Bulimia Nervosa (307.51) is characterized by binge eating that is compensated by a purging method designed to prevent weight gain. Individuals who suffer from this disorder typically have their self-evaluation excessively influenced by their body shape and/or weight. They also typically consume an excessive amount of food in a short period of time and then use some compensatory technique to avoid a weight gain. The diagnostic criteria are given below.

A. Recurrent episodes of binge eating in which they eat an excessive amount of food, for example, within a two-hour period, that is clearly larger than most people would eat in a similar period of time. This is accompanied by a sense of a lack of control over how much they are eating during this episode.

B. Recurrent inappropriate compensatory behavior is used to avoid a weight gain including self-induced vomiting; the misuse of laxatives, diuretics, enemas and/or other medications; or excessive exercising.

C. The binge eating and inappropriate compensatory behavior occur on the average at least twice a week and have been present for three months.

D. The individual’s self-evaluation is unduly influenced by their weight and body shape.

E. These disturbances do not occur exclusively during episodes of Anorexia Nervosa.

Finally, it is necessary for the diagnosing doctor to distinguish between the two distinct types of Bulimia Nervosa: the Purging Type and the Nonpurging Type. The Purging Type is specified when the individual has regularly self-induced vomiting and/or has misused laxatives, diuretics and/or enemas. The Nonpurging Type is specified
when, during the most recent episode, the individual has not engaged in purging but has used other techniques such as excessive exercise and/or fasting.

**XI. Dissociative Disorders**

According to the DSM-IV-TR, the Dissociative Disorders are characterized by prominent features of dissociation or a disruption in the integration of consciousness, memory, identity and/or sensation or perception. In this regard, dissociation is the partial or total disconnection or dissociation between past memories, awareness of one’s identity, awareness of immediate sensations or perceptions, and the control of body movements. All of these conditions are thought to be the result of traumatic experiences.

1. **Dissociative Amnesia (300.12)**

   According to the DSM-IV-TR, Dissociative Amnesia is characterized by an inability to recall important relatively recent events and personal information. The material “forgotten” is typically too extensive to be explained by normal forgetting and appears to be due to an experience of a stressful or traumatic nature. The specific DSM-IV-TR diagnostic criteria are given below.

   A. The person must exhibit one or more episodes in which they demonstrate an inability to recall important personal information, which is usually stressful or traumatic, and which cannot be explained by normal or ordinary forgetfulness.
   B. The disturbance does not occur as part of another DSM-IV-TR disorder such as a Posttraumatic Stress Disorder or an Amnestic Disorder Due to Head Trauma.
   C. The loss of functioning causes clinically significant distress and/or impairment in social, occupational and/or other areas of functioning.
2. **Dissociative Identity Disorder (300.14)**

According to the DSM-IV-TR, a Dissociative Identity Disorder is diagnosed correctly when the individual presents with evidence of having two or more distinct personalities or identities. In earlier diagnostic manuals this disorder was called a Multiple Personality Disorder. It has been written about and covered extensively in the popular press. The specific diagnostic criteria are given below.

A. The presence of two or more distinct personalities or identities with each having its own behaviors regarding thinking about, perceiving, and/or relating to the environment and/or themselves.
B. At least two of the personalities take control of the individual’s behavior at different times.
C. There is an inability of the personalities to recall important personal information that cannot be explained by normal forgetfulness.
D. The disturbance is not due to the direct physiological effects of a substance and/or a general medical condition.

3. **Depersonalization Disorder (300.6)**

The DSM-IV-TR defines a Depersonalization Disorder as being characterized by persistent and/or recurrent episodes during which an individual feels detached and/or estranged from oneself. He or she may have the sensation of living in a dream, and/or have the sensation of being an outside observer viewing oneself. The diagnostic criteria for a Depersonalization Disorder are given below.

A. The individual has persistent and/or recurring depersonalized experiences consisting of feeling detached from oneself and one’s mental processes and/or body, as if one were an outside observer or were in a dream.
B. During the depersonalized experiences described above, the individual does not lose contact with reality.
C. The depersonalized experiences cause clinically significant distress and/or impairment in social, occupational and/or other areas of functioning.
D. The depersonalized experiences do not occur during the course of another DSM-IV-TR mental disorder such as Schizophrenia and are not due to the direct physiological effects of a substance and/or a general medical condition such as epilepsy.

XII. Sexual and Gender Identity Disorders

This class of disorders is composed of three subtypes: Sexual Dysfunctions, Paraphilias and Gender Identity Disorders. These three subtypes are rarely at issue in personal injury or workers’ compensation litigation. In fact, the frequency of these disorders in cases seen in my office is very low compared to the frequency of these disorders in the general population. The most likely cause for this situation appears to be that individuals who suffer from these conditions simply decline to make these disorders part of their history, deeming them irrelevant to their litigation. In this regard, only the most persistent and subtle historian will be able to obtain the relevant data. Nevertheless, while these disorders are rarely found in litigants, the many varieties of these conditions are discussed below.

Sexual Dysfunctions are characterized by a disturbance in what is deemed to be normal sexual desires and/or in the psychophysiological changes that are characteristic of the sexual response cycle. Sexual Dysfunctions cause marked distress and interpersonal difficulty. The Paraphilias are characterized by recurrent and intense sexual urges, fantasies and/or behaviors that involve “unusual objects, activities or situations.” These disorders not only cause distress but may also occasion impairments in normal social, occupational and/or other areas of functioning. Finally, Gender Identity Disorders are characterized by strong and persistent discomforting feelings about one’s biological gender accompanied by a desire to be regarded as a member of the opposite gender. Once again, impairments in normal social, occupational and/or other areas of functioning characterize these disorders.
1. Sexual Dysfunctions

a) **Hypoactive Sexual Desire Disorder (302.71)**

   According to the DSM-IV-TR, the essential feature of a Hypoactive Sexual Desire Disorder is a deficit or absence of sexual fantasies as well as a lack of a desire for sexual activity. The diagnostic criteria are presented below.

   A. A persistent or recurring deficit or absence of sexual fantasies as well as a lack of desire for sexual activity taking into account such variables as the person’s age and life situation.
   B. The deficits or absences cause marked distress and/or interpersonal difficulty.
   C. The deficits or absences are not caused by another Axis I mental disorder, other than another Sexual Dysfunction, and are not solely due to the direct physiological affects of a substance and/or a general medical condition.

b) **Sexual Aversion Disorder (302.79)**

   According to the DSM-IV-TR, a Sexual Aversion Disorder is diagnosed correctly when there is an aversion to, as well an active avoidance of, all or almost all genital sexual contact with a sexual partner. The diagnostic criteria are presented below.

   A. A persistent or recurring “extreme aversion” to and avoidance of all, or almost all, genital sexual contact with a sexual partner.
   B. The aversion or avoidance causes marked distress and/or interpersonal difficulty.
   C. The aversion or avoidance is not better accounted for by another Axis I disorder except for another Sexual Dysfunction.
c) **Female Sexual Arousal Disorder (302.72)**

According to the DSM-IV-TR, the essential feature of a Female Sexual Arousal Disorder is a persistent or recurring inability to attain or maintain an adequate lubrication-swelling response of sexual excitement until completion of the sexual activity. The diagnostic criteria are presented below.

A. A persistent or reoccurring inability to attain or to maintain “an adequate lubrication-swelling response of sexual excitement” until the completion of the sexual activity.
B. The inability described in Criterion A causes marked distress and/or interpersonal difficulty.
C. The inability described in Criterion A is not better accounted for by another Axis I disorder, except another Sexual Dysfunction, and is not due exclusively to the direct physiological effects of a substance and/or a general medical condition.

d) **Male Erectile Disorder (302.72)**

According to the DSM-IV-TR, the essential feature of a Male Erectile Disorder is a persistent or recurrent inability to attain or to maintain an adequate erection until the completion of sexual activity. The diagnostic criteria are presented below.

A. A persistent or reoccurring inability to attain or to maintain an adequate erection until the completion of sexual activity.
B. The inability causes marked distress and/or interpersonal difficulty.
C. The dysfunction is not better understood as being due to another Axis I disorder, unless it is another Sexual Dysfunction, and it is not due exclusively to the direct physiological effects of a substance and/or a general medical condition.
e) **Female Orgasmic Disorder (302.73)**

According to the DSM-IV-TR, the essential feature of a Female Orgasmic Disorder is a persistent or recurring delay in or absence of an orgasm following a normal sexual excitement phase. The diagnostic criteria are presented below.

A. A persistent or recurring delay in or absence of an orgasm following a normal sexual excitement phase based on what is reasonable for the woman’s age, sexual experience and the adequacy of the stimulation.

B. The dysfunction causes marked distress and/or interpersonal difficulty.

C. The dysfunction is not better accounted for by another Axis I disorder, except another Sexual Dysfunction, and is not due exclusively to the direct physiological effects of a substance and/or a general medical condition.

f) **Male Orgasmic Disorder (302.74)**

According to the DSM-IV-TR, the essential feature of a Male Orgasmic Disorder is a persistent or recurring delay in or absence of an orgasm that follows a normal sexual excitement phase. The diagnostic criteria are presented below.

A. A persistent or recurring delay in or absence of an orgasm that follows a normal sexual excitement phase based on the man’s age and whether the source of stimulation is adequate in focus, intensity and duration.

B. The dysfunction causes marked distress and/or interpersonal difficulty.

C. The dysfunction is not better accounted for by another Axis I disorder, except another Sexual Dysfunction, and is not due exclusively to the direct physiological effects of a substance and/or a general medical condition.
g) **Premature Ejaculation (302.75)**

According to the DSM-IV-TR, the essential feature of Premature Ejaculation (302.75) is the persistent or recurrent onset of an orgasm and ejaculation before the man wishes it to occur. The diagnostic criteria are presented below.

A. A persistent or recurrent orgasm and ejaculation that occurs with minimal sexual stimulation either before or shortly after penetration and before the man wishes it to occur taking into account the man’s age, the novelty of the sexual partner or the situation, and the recency of other sexual activity.

B. The dysfunction causes marked distress and/or interpersonal difficulty.

C. The premature ejaculation is not due to the effects of a substance.

h) **Dyspareunia (302.76)**

According to the DSM-IV-TR, the essential feature of Dyspareunia is genital pain that is not due to a general medical condition that is associated with sexual intercourse. The diagnostic criteria are presented below.

A. A persistent or recurring pain in the genitals of either a male or a female that is associated with sexual intercourse.

B. The dysfunction causes marked distress and/or interpersonal difficulty.

C. The dysfunction is not caused exclusively by a lack of female lubrication or Vaginismus and is not better accounted for by another Axis I disorder, except another Sexual Dysfunction, nor is it due exclusively to the direct physiological effects of a substance and/or a general medical condition.
i) **Vaginismus (306.51)**

According to the DSM-IV-TR, the essential feature of Vaginismus is a recurring or persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when an attempt is made at penetration. The diagnostic criteria are presented below.

A. A recurring or persistent involuntary contraction or spasm of the musculature of the outer third of the vagina when an attempt is made at penetration, resulting in an interference with sexual intercourse.

B. The dysfunction causes marked distress and/or interpersonal difficulty.

C. The dysfunction is not better accounted for by another Axis I disorder and is not due to the direct physiological effects of a general medical condition.

2. **Paraphilias**

a) **Exhibitionism (302.4)**

According to the DSM-IV-TR, Exhibitionism is diagnosed correctly when one exposes one’s genitals to a stranger. The diagnostic criteria are presented below.

A. The individual has had recurrent and intense sexually arousing fantasies, sexual urges, and/or behaviors that involve exposing their genitals to an unsuspecting stranger. In addition, these occurrences have taken place over a period of at least six months.

B. The individual has acted on these urges and/or these urges or fantasies have caused marked distress and/or interpersonal difficulties.
b) **Fetishism (302.81)**

According to the DSM-IV-TR, the essential feature of Fetishism is the use of nonliving objects to achieve sexual gratification. The diagnostic criteria are presented below.

A. The individual has had recurrent intense sexually arousing fantasies, sexual urges or behaviors that involve the use of nonliving objects, such as articles of clothing, to obtain sexual gratification.

B. The behaviors engaged in cause significant distress and/or impairment in social, occupational and/or other areas of functioning.

C. The objects used are not limited to articles of clothing or devices designed to provide tactile genital stimulation.

d) **Frotteurism (302.89)**

According to the DSM-IV-TR, the essential feature of Frotteurism is rubbing against and/or touching a non-consenting individual. The diagnostic criteria are presented below.

A. The individual has recurrent and intense sexually arousing fantasies, sexual urges and/or behaviors that involve rubbing and/or touching a non-consenting individual.

B. The fantasies, urges and/or behaviors cause clinically significant distress or impairment in social, occupational and/or other important areas of functioning.

d) **Pedophilia (302.2)**

According to the DSM-IV-TR, the essential feature of Pedophilia is having sexual activity with a prepubescent child, that is, one that is generally 13 years of age or younger. The diagnostic criteria are presented below.
A. The individual has had or has engaged in recurrent and intense sexually arousing fantasies, urges and/or behaviors, over a period of six months or more, involving sexual activity with one or more prepubescent children, which is generally taken to mean someone 13 years old or younger.

B. The fantasies, urges and/or behaviors cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

C. The person diagnosed with Pedophilia is at least 16 years old and 5 years or more older than the children with whom they are active.

e) **Sexual Masochism (302.83)**

According to the DSM-IV-TR, Sexual Masochism is defined as a sexual act in which one is humiliated, beaten, bound and/or otherwise made to suffer. The diagnostic criteria are presented below.

A. The individual has had or has engaged in recurrent and intense sexually arousing fantasies, urges and/or behaviors, over a period of six months or more, in which they have been humiliated, bound, beaten and/or been made to suffer in some other fashion.

B. The fantasies, urges and/or behaviors cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

The DSM-IV-TR considers hypoxyphilia as a type Sexual Masochism. Hypoxyphilia requires oxygen deprivation by use, for example, of a noose or a plastic bag to produce a decrease in brain oxygenation resulting in an enhanced sexual excitation. Unfortunately, this procedure often produces death by accidental asphyxia. It is known in the popular press as autoerotic asphyxia, a result that sometimes needs to be legally distinguished from suicide.

f) **Sexual Sadism (302.84)**
According to the DSM-IV-TR, Sexual Sadism is defined as a sexual act in which the individual derives sexual excitement from the psychological and/or physical suffering of another person. The diagnostic criteria are presented below.

A. The individual has had or has engaged in recurrent and intense sexually arousing fantasies, urges and/or behaviors, over a period of six months or more, in which the psychological and/or physical suffering of another person is sexually exciting.
B. The fantasies, urges and/or behaviors cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

g) Transvestic Fetishism (302.3)

According to the DSM-IV-TR, the essential feature of Transvestic Fetishism is what is more commonly called cross-dressing. The diagnostic criteria are presented below.

A. A heterosexual male has had or has engaged in recurrent and intense sexually arousing fantasies, urges and/or behaviors, over a period of six months or more, as a result of cross-dressing, or wearing the clothes of a woman.
B. The fantasies, urges and/or behaviors cause clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

h) Voyeurism (302.82)

According to the DSM-IV-TR, the essential feature of Voyeurism is viewing an unsuspecting individual, who is typically a stranger and who is naked, disrobing or engaging in sexual activity. The diagnostic criteria are presented below.

A. The individual has had or has engaged in recurrent and intense sexually arousing fantasies, urges and/or behaviors,
over a period of six months or more, in which they have observed an unsuspecting person who is either naked, in the process of taking off their clothes or who is engaging in sexual activity.

B. The fantasies, urges and/or behaviors cause clinically significant distress and/or impairment in social, occupational and/or other significant areas of functioning.

3. Gender Identity Disorders

In order to diagnose a Gender Identity Disorder correctly the individual must meet two major diagnostic criteria. First, there must be data indicating that there is a strong and persistent cross-gender identification that is defined as the desire to be a member of the opposite gender or an insistence that one is a member of the opposite gender. Second, there must also be data indicating that there is a persistent discomfort about one’s gender or a sense of inappropriateness of the behavior of one’s gender. While Gender Identity Disorders can be observed in children and adolescents as well as adults, we will confine our discussion to the latter. The diagnostic criteria are presented below.

A. A strong and persistent cross-gender identification in which the individual demonstrates a desire to be a member of the opposite gender or insists they are a member of the opposite gender.

B. There must be persistent discomfort with one’s gender or a sense of inappropriateness in the role of that gender.

C. The disturbance is not concurrent with a “physical intersex condition” or what is typically called hermaphroditism, a condition in which an individual has both male and female sexual organs, usually with one gender dominating.

D. The disturbance must cause clinically significant distress or impairment in social, occupational and/or other important areas of functioning.

As you will note, no numerical diagnostic code was provided above for a Gender Identity Disorder. This is because different numerical diagnostic codes are used for this disorder depending on
the specifiers, which vary according to whether the individual is a child, an adolescent or an adult, and is attracted to males, to females, to both genders or to neither gender. Further information about these numerical diagnostic codes is found on page 582 of the DSM-IV-TR.

XIII. Factitious Disorders

A Factitious Disorder is characterized by the intentional production of physical and/or psychological signs and/or symptoms, including the report of complaints that do not exist as well as the production of real physical signs by deliberately and adversely affecting one’s physical status. In order to diagnose this disorder correctly it is necessary to demonstrate that the individual has assumed the role of a sick person and to eliminate the possibility that their behavior is determined by external incentives, such as winning a lawsuit. The DSM-IV-TR criteria are given below.

A. The intentional production or faking of physical and/or psychological signs and/or symptoms.
B. The individual has faked the signs and/or symptoms in order to assume the role of a sick person.
C. There are no external incentives such as economic gain or the avoidance of legal responsibilities. The individual is not Malingering, as defined by the DSM-IV-TR, and discussed below.

There are three different forms of Factitious Disorder depending on the signs and/or symptoms presented by the individual. If the individual presents with predominantly psychological signs and/or symptoms, the correct diagnosis is Factitious Disorder With Predominantly Psychological Signs and Symptoms (300.16). If the individual presents with predominantly physical signs and/or symptoms, the correct diagnosis is Factitious Disorder With Predominantly Physical Signs and Symptoms (300.19). If the individual presents with both psychological and physical signs and/or symptoms the correct diagnosis is Factitious Disorder With Combined Psychological and Physical Signs and Symptoms (300.19).
XIV. Conditions That May Be a Focus of Interest

The DSM-IV-TR delineates Conditions That May Be a Focus of Interest to a diagnosing and/or treating mental health professional but are not mental or psychological disorders. These conditions frequently come to the attention of mental health professionals when individuals present at their offices and request assistance with these problems. The most frequently seen Conditions That May Be a Focus of Interest are: Psychological Factors Affecting Medical Condition (316.00), a Parent-Child Relational Problem (V61.20), a Partner Relational Problem (V61.10), a Sibling Relational Problem (V61.8), Noncompliance With Treatment (V15.81), Malingering (V65.2), Borderline Intellectual Functioning (V62.89), Bereavement (V62.82), an Occupational Problem (V62.2), an Identity Problem (313.82) and a Phase of Life Problem (V62.89).

1. Psychological Factors Affecting Medical Condition (316.00)

   Psychological Factors Affecting Medical Condition (316.00) is specified correctly when one or more psychological or behavioral factors have affected a general medical condition found in the patient. In order to use this category, there must be information in the form of medical records and psychological data showing that the individual’s signs and/or symptoms are indicative of a specific medical condition and are not completely understandable in terms of the underlying physical pathology and/or an attempted simulation of symptoms.

2. Parent-Child Relational Problem (V61.20)

   A Parent-Child Relational Problem (V61.20) is specified correctly when an interaction between a parent and a child has created impairment in individual and/or family functioning or significant signs and/or symptoms in the parent or the child.
3. **Partner Relational Problem (V61.10)**

A Partner Relational Problem (V61.10) is specified correctly when the focus of clinical attention is a pattern of interaction between spouses or partners, such as problematic communications, that has created a significant impairment in individual and/or family functioning and/or signs and/or symptoms in one or more of the partners.

4. **Sibling Relational Problem (V61.8)**

A Sibling Relational Problem (V61.8) is specified correctly when the focus of clinical attention is a pattern of interaction between siblings, such as problematic communications, that has created a significant impairment in individual and/or family functioning and/or signs and/or symptoms in one or more of the siblings.

5. **Noncompliance With Treatment (V15.81)**

Noncompliance With Treatment (V15.81) is specified correctly when there is evidence that the individual is not compliant with an important aspect of their treatment for a mental and/or general medical condition and this noncompliance has created a severe problem.

6. **Malingering (V65.2)**

Malingering (V65.2) is specified correctly when an individual has intentionally produced false or grossly exaggerated signs and/or symptoms of a physical and/or psychological nature, and that deliberate misrepresentation is motivated by external incentives such as obtaining financial compensation, avoiding work, or evading military duty. In contrast, a Factitious Disorder is diagnosed when there is evidence that the individual has behaved in a manner to assume the role of a sick person and the possibility has been eliminated that their behavior has been motivated by obtaining
external incentives such as obtaining financial compensation, avoiding work, or evading military duty. According to the DSM-IV-TR, Malingering should be strongly suspected if there is a combination of any of the following:

A. An attorney refers the individual for an evaluation and/or treatment.
B. There is a marked discrepancy between the individual’s claimed stress or disability and the objective findings.
C. There is a lack of cooperation with the evaluator’s procedures and/or the treatment prescribed.
D. The individual presents with an Antisocial Personality Disorder.

7. **Borderline Intellectual Functioning (V62.89)**

Borderline Intellectual Functioning (V62.89) is specified correctly when the focus of attention is a below normal level of intellectual functioning that is defined as an Intelligence Quotient (I.Q.) in the 71 to 84 range.

8. **Bereavement (V62.82)**

Bereavement (V62.82) is specified correctly when the focus of attention is a reaction to the death of a significant person in one’s life. Individuals who present with Bereavement may have signs and/or symptoms analogous to a clinical depression. However, a Depressive Disorder is not diagnosed unless the signs and/or symptoms present for an unrealistically long period of time.

9. **Occupational Problem (V62.2)**

An Occupational Problem (V62.2) is specified correctly when the individual presents with one or more problems stemming from their occupation, and the problems are not due to a mental disorder or, if the problems are due to a mental disorder, there is dysfunction that is sufficiently severe to warrant independent attention.
Occupational problems may be caused by a variety of factors including job dissatisfaction and uncertainty about career choices.

10. **Identity Problem (313.82)**

An Identity Problem (313.82) is specified correctly when the individual presents with uncertainty about issues relating to their identity, such as their career choice, friendship patterns, sexual orientation and/or moral values.

11. **Phase of Life Problem (V62.89)**

A Phase of Life Problem (V62.89) is specified correctly when the individual presents at the clinician's office with a problem that is associated with a particular developmental phase or another life circumstance problem that is not due to a mental disorder. Some such problems include starting a new career, leaving parental control, divorce and retirement.

XV. **“Diagnosing” No Disorders or Deferring Diagnosis**

1. **No Diagnosis or Condition on Axis I (V71.09)**

When the individual does not have an Axis I disorder or a Condition That May Be a Focus of Interest, the appropriate “diagnosis” that is recorded on Axis I is “No Diagnosis or Condition on Axis I (V71.09).”

2. **No Diagnosis on Axis II (V71.09)**

When the individual does not have a Personality Disorder and is not mentally retarded the doctor designates, “No Diagnosis on Axis II (V71.09).”

3. **Diagnosis or Condition Deferred on Axis I (799.9)**
A “Deferred” diagnosis on Axis I is used when an examiner has “Information inadequate to make any diagnostic judgment about an Axis I diagnosis or condition.” Specifically, if the doctor does not have adequate information to diagnose an Axis I disorder or a Condition That May Be a Focus of Interest, this is the manner in which that information is conveyed.

4. Diagnosis Deferred on Axis II (799.9)

A “Deferred” diagnosis on Axis II is used when an examiner has “Information inadequate to make any diagnostic judgment about an Axis II diagnosis.” Specifically, for adults, if the doctor does not have adequate information to diagnose a Personality Disorder or a form of Mental Retardation, this is the manner in which that information is conveyed.
Chapter 4

The Mental Status Examination

As previously defined, a Mental Status Examination (MSE) provides observations of the patient that are made by the doctor employing a relatively standard set of examining techniques and questions. Data that also find their way into a report of the doctor’s Mental Status Examination include observations that are made during the patient’s entering and leaving the consulting room as well as those made during the remainder of the face-to-face clinical interview.

I. Mental Status Examinations in Neurology and Psychology

Mental Status Examinations grew out of the field of neurology. Traditionally they have been used to discriminate between individuals who have neurological conditions that are sometimes called brain damage, organicity, an organic brain syndrome, or a neuro-behavioral disorder, and those who have a psychological disorder, most frequently a clinical depression. For our purposes we will use the simple term “brain damage” instead of any of the other possibilities. There are many causes of brain damage, all of which are beyond the scope of this text.

The need for an examination to discriminate between brain damage and psychological disorders, particularly clinical depression, arose out of the fact that these two conditions often superficially present with the same signs and/or symptoms. In fact, the frequency of brain damage mimicking psychopathology has led two of the leaders of neurological diagnosis to state, “A full mental status examination should be performed on all psychiatric patients, particularly those whose psychiatric symptoms have appeared rather acutely and are superimposed on a life history of normal emotional functioning” (Strub & Black, 1993). Thus, virtually all psychological evaluations include a Mental Status Examination, which as it turns out, provides a wide variety of information about an individual’s psychological status as well as data concerning any possible brain damage.
II. Contents of a Mental Status Examination

The doctor’s report of their Mental Status Examination provides a detailed description of the patient as the doctor observed that person, principally in the consulting room. The Mental Status Examination report does not provide a set of complaints or a description of the person’s symptoms. Similarly, the Mental Status Examination report does not contain a history of what happened to the patient nor does it discuss the results of the psychological testing. The Mental Status Examination report also does not provide any clinical conclusions other than the ones that can be drawn from the direct observations made during the course of the Mental Status Examination. In this regard, if the doctor observes some signs of depression they will undoubtedly point out that what they have observed is either indicative of or consistent with a clinical depression. Perhaps the entire purpose of the Mental Status Examination can be broken down into two questions, the first being more important than the second: First, what did the doctor observe? And, second, what does it mean? In this regard, the doctor’s report of their Mental Status Examination should clearly describe all of a set of observable elements common to all such examinations.

In reading a report of a Mental Status Examination you will typically discover that the doctor has written it with descriptions of the most general observations of the simplest types of behavior first, and the most specific observations of the more complex behaviors last. The first things that the doctor typically observes and describes are the patient’s orientation and physical presentation.

III. The Patient’s Orientation

Probably the most general piece of information that is obtained in the Mental Status Examination is the orientation of the person examined. This portion of the Mental Status Examination survives from examining relatively severely brain-damaged individuals, usually in the context of their hospital room. Without doubt, most individuals who present themselves for an examination in a medical-legal context do not have any orientation problems and this portion of the examination is simply a pro forma matter of making the patient’s
record complete. Nevertheless, without necessarily being direct, patients are asked if they know who they are, their age, their birth date, where they are, their home address, the date, the day of the week, the time of the day, the season and the year. They will also typically be asked how they got to the office and if they know why they are being evaluated. Persons with severe brain damage may not be able to provide this simple information. However, at times individuals who are trying to appear dysfunctional, but in reality are attempting to feign dysfunction, may deliberately provide incorrect information to some of these questions, but will trip themselves up later in the interview when they will be able to provide more complex information quite readily.

For example, at the beginning of every medical-legal examination it is my standard procedure to make sure that the individual understands the reason for their visit to my office and to have them sign an informed consent statement. That statement indicates that they not only know they are in my office for a psychological evaluation in conjunction with their claim or litigation but that the information they provide me will not be held in confidence but sent to the attorneys involved in the case and/or the insurance company. In fact, an office assistant typically completes this process and I usually do not get to talk with the person before that statement is signed. Nevertheless, after having the discussion with the office assistant and signing the form, during the interview with me some patients say they have no idea why they are in the office. However, later in the examination they may tell me some very explicit details of their litigation, including reciting complex information from a recent deposition. Clearly, this suggests that I am not getting a complete and honest accounting of their history and that I should be on the lookout for distortions in their Mental Status Examination performance as well as other aspects of the evaluation. Obviously, one of the major facets of any medical-legal psychological evaluation is to look for and account for inconsistencies in information between the five sources of information as well as within any given information source. This is not true when evaluating people who have simply come to my office for assistance with a psychological problem, where it can generally be accepted that I’m going to hear the truth.
Initially, every medical-legal examiner approaches every forensic clinical interview with the idea of attempting to develop some rapport with the person being evaluated. In this regard, there are no sure-fire rules for behaving. What might work well with one person will turn out to be a disastrous attempt with another. The development of rapport is part of the clinical skill and judgment that comes with years of experience. Nevertheless, after the initial interaction, described above, that occurs in obtaining information about their orientation and physical appearance, the next task typically is to obtain data about their general behavior and to place that information in the report. The first piece of such data is the person’s affect or emotional reaction on meeting the interviewer. Among the multitude of possibilities are: were they friendly, withdrawn, cooperative, unsmiling, tense, communicative, well-spoken, terse, distressed, relaxed, insightful, apprehensive, unsophisticated, hostile, angry, or verbose. Clearly, a friendly, smiling, relaxed, insightful and communicative person would be much less likely to be suffering from a severe clinical depression than someone whose initial affect was tense, withdrawn, hostile and angry. Also relevant here is whether or not the patient developed some rapport with the interviewer and how easily this came about. It is also important to observe and comment on the nature of their narrative, specifically, on the appropriateness of the detail they provide, whether it was sparse, over-inclusive or normal for the situation. Did they speak in a calm and self-assured manner in a natural tone of voice or did they speak in a barely heard voice, yell, speak non-stop or provide little or no speech at all. All of this information addresses their psychological status and the possibility that they have a psychological disorder.

IV. The Patient’s Physical Presentation

People with different types of psychological disorders, normal individuals, and those with brain damage may appear physically different. In this regard, it is well known that clinically depressed individuals often appear disheveled and completely unconcerned with their physical appearance and taking care of themselves. On the other hand, a person with obsessive-compulsive behaviors would be much more likely to present with an impeccable appearance. While it
may not always be true that first impressions make a difference, how a person initially appears is often a statement about their mental status. Thus, after discussing the patient’s general orientation, the first thing a doctor writing a report of their Mental Status Examination will probably tell you is what the patient looked like. This is helpful because it assists the reader in developing a mental picture of the person being evaluated. Accordingly, in the beginning of almost every Mental Status Examination report you will find information about the patient’s physical appearance. Normally the doctor will describe their apparent age, height, weight, posture, clothing, hair, and appropriateness of their grooming as well as data about the timeliness of their appearance in the office and their expressed ease of finding their way to the appointment.

Another occasional occurrence that can speak volumes about a person’s psychological status is their locomotion and/or gait. Since many people claiming psychological injuries have also suffered physical injuries, it is not unusual to have patients enter my office in a wheelchair, to be assisted with walkers or canes, or to present with pronounced limps and difficulty ambulating. However, there are times when observations can be made outside of my office that may be relevant to their psychological status. On more than one occasion in arriving at my office at approximately the same time as a patient, unbeknownst to them I have observed them ambulating without any difficulty until they get to my front door at which time they affected a pronounced physical disability. While I am clearly not trained as an orthopedist and cannot comment on their orthopedic condition, I most assuredly can testify to what I have observed with regard to their locomotion prior to and after entering my office.

Similarly, on occasions I have observed claimants coming to my office with a friend or a relative in what is obviously an upbeat mood as observed by their laughing and smiling in interacting with their friend or relative prior to entering my office. On rare occasions their presentation on entering my office immediately changes to projecting a dejected and downtrodden mood. Under these conditions what am I left to conclude? It seems that my only realistic alternative is to consider that the person is going to attempt to portray him or herself as having some psychological issues that do not exist.
At the very least, I enter the examination process with that thought as a hypothesis to be considered and evaluated by the data I collect.

Finally, in observing an individual’s general behavior it is relevant to describe their motor behavior, commenting on any unusual patterns of coordination, gait, activity level, locomotion, apparent physical pain, mannerisms, grimaces and the level of eye contact made with the examiner. It is also important to describe their linguistic skills, judgment, insight, psychological-mindedness and ability to articulate or describe their thoughts, behaviors and feelings. Observations of these multiple dimensions are all relevant to developing a well-rounded and complete picture of the person being evaluated, as they provide extensive information about their psychological status. In most cases these data are not obtained by applying any particular techniques or asking any specific questions. They come out of the overall conversation with the examinee. Nevertheless, conclusions about these factors are based on observations made by the doctor that can be placed in the physician’s report. Unfortunately, some doctors may never do so, being content to provide their summarily stated conclusions and hoping that the court will accept them at face value. In fact, nothing should ever find its way into a psychologist’s medical-legal report that cannot be backed up with observational data.

V. The Patient’s Mood

Having reached this portion of the interview, one typically has a fairly good idea about the person’s psychological status. However, one cannot stop with the data collection process, as there is much more to learn. One major question to be answered concerns the individual’s mood. Is the patient’s mood normal or are they angry, anxious or depressed? The purpose of this segment of the examination, as well as the corresponding portion of the report, is to describe the patient’s mood. Essentially, one asks and looks for answers to general questions such as: What is the person feeling? What do they think and feel about themselves and their lives? This is done throughout the interview process by getting the person to talk about him or herself, significant others, and events in their lives. It is
also done by observing what they do as well as what they say and how they say it.

In regard to the above-described feeling states, having developed a reasonable amount of rapport with the interviewer, individuals who are clinically depressed will talk about feelings and thoughts of worthlessness, hopelessness, helplessness, incompetence, self-reproach, guilt, pessimism, failure, a loss of interest in pleasure, demoralization and thoughts of death and/or suicide. Even when the patient is not asked directly, they will frequently complain of fatigue, weight changes when not dieting or attempting to gain weight, insomnia, frustration, anger and/or decreased libido. Moreover, in listening to them talk they can often be observed to exhibit what for them is reduced cognitive functioning, abnormally slowed or agitated behavior, attention deficits, sadness, tearfulness, irritability, indecisiveness and evidence of social withdrawal. Conclusions about their feelings, which are backed up by specific examples of their verbalizations and behavioral observations, should be found at this point in the doctor’s report.

While individuals who are clinically depressed often talk about the things described above, people who are clinically anxious tend to talk about different things. Specifically, they can be expected to talk about unrealistic fears and/or worries. In talking about themselves and their lives, their narrative typically contains themes of threat, danger, unpredictability, uncertainty or terror. Even before an attempt is made to obtain a complete history of their current complaints they may speak of having chest tightness or pain, shortness of breath, heart palpitations, racing heartbeats, choking and/or smothering, diarrhea, frequent urination, tingling sensations in the extremities, dizziness, lightheadedness, cold sweats, hot flashes, dry mouth, shaking, jitteriness and/or trembling. Additionally, when observed in the consulting room they will often exhibit fidgeting, restlessness, hand wringing, a strained voice, tremulousness, tension, motor hyperactivity, jumpiness, autonomic hyperactivity, vigilance, scanning and/or poor reality testing. Once again, these observations find their way into the doctor’s report of their Mental Status Examination. Or, at the very least, if observations of these narrative expressions or behaviors were made during another portion of the examination process, the doctor will make note of this in their report.
Clearly, the above discussion of anxiety and depression is not an inclusive list of all of the possible observations that can be made of a person’s narrative. In fact, it would be almost impossible to make a complete list and probably an exceptionally boring one to read. Let’s just note that at this stage of the Mental Status Examination the job of the interviewer is to keep their ears and eyes open and take in all of the information that is being provided by the patient regardless of where that information might lead and what it might reveal. To mention just a few, it would not be unusual at this stage of the interview to gain information about the person in the following areas: trust of others, preferences for relationships, openness, honesty, trustworthiness, emotional consistency, assertiveness, self-centeredness, and dependence. In fact, many people when given the opportunity will just go on for an extended period of time and provide all sorts of information not explicitly asked for, that may or may not be relevant. At that point the interviewer may be forced to gently take more control of the interview process in order to complete the examination within a reasonable period of time.

VI. The Patient’s Memory

Individuals with various mental disorders frequently have cognitive problems in the area of memory. Historically, memory functions have been divided into three types: immediate, recent and remote. Objective data about all three types of memory are easily obtained during the normal course of a Mental Status Examination.

Short-term memory can be assessed by presenting a digit memory task. In this test the individual is verbally presented with a series of digits at the rate of approximately one per second and asked, after hearing all of the numbers, to repeat the entire series in the order in which it was given. Typically, the examiner starts with a series of digits that they fully expect the person to recall with ease. This might be a three digit series. Generally, the examiner continues to lengthen the series until the person fails two sets of numbers in a row. In a similar task, the person is again asked to recall a series of digits but this time they are asked to recall them in the reverse order, so if the examiner says, “1-2-3” the person must respond, “3-2-1.” The first task is much easier than the second and a person with a
high school education can be expected to recall 5 to 7 digits forward and 4 or 5 digits backward.

When memory problems are discovered in the consulting room it is important to try to determine if the difficulties are actually due to a memory deficit or a problem in attending or concentrating to the task at hand. Attention refers to the person’s ability to regard a specific aspect of their environment without any or with minimal distraction. Concentration is the ability to attend on a more or less continuous basis for an extended period of time. That is, concentration simply involves a relatively long period during which one attends to a task. In the context of the consulting room, mental status examiners often assess attention and concentration by simply noticing when the person is distracted and seemingly cannot complete or perform tasks because of their inability to focus. However, they also may use specific tests to assess attention and concentration, as discussed below. There are also relatively simple tasks that can be used for determining if a problem in performing a short-term memory task is due to difficulty with memory, on the one hand, or attention or concentration on the other. One such task is called a Random Letter Task. It involves reading a list of letters to the person and asking them to raise a finger when they hear a particular letter, say an M. The letters used are randomly generated except for the letter M's, which are inserted at a relatively high frequency. A person with intact attention and concentration processes should be able to listen to a series of approximately 100 letters with approximately 25 of them being M's and make no more than one or two errors. However, the Random Letter Task is not necessary to administer if the person has demonstrated a high level of performance on the digit memory task, since one must be able to attend and concentrate at a high level to perform that task successfully. Quite simply, if a person performs successfully on a short-term memory task we can assume that they not only are able to perform memory tasks successfully but that they also can attend and concentrate at a normal level.

Recent memory involves the ability to learn new material and then to be able to recall that material after a reasonably short period of time. In the context of the consulting room, one measure of recent memory involves identifying three objects in the examination room and then asking the person to recall that information after a short
period of time. For example, the doctor may point out three unrelated objects in the room and then, after proceeding to some other tasks for approximately five minutes, ask the patient to recall the names of those three objects. If one is interested in a more careful test of recent memory Strub and Black suggest using four unrelated words that they identify as “Brown, Honesty, Tulip and Eyedropper.” Strub and Black have provided published data for various age groups showing what normal individuals can recall after 10 minutes (Strub & Black, 1993). Yet another recent memory test is simply to ask the patient to recall the doctor’s name. However, this test is quite informal and does not yield any information that can lead to a precise conclusion like the Strub and Black test can. Finally, another simple test of recent memory is to read the patient a brief story that contains 15 to 20 details. The Cowboy Story Test, a classic, is described in the chapter on psychological testing. In this test the examiner reads, or allows the person being tested to read, a paragraph describing the behavior of a “cowboy” who went to San Francisco with his dog and bought some new clothes. The patient is then asked to recall as many of the items in the story as they can and their performance is objectively scored and compared to normative data that allows for conclusions to be drawn about the nature of their memory.

Remote memory, or what is sometimes called long-term memory, can be assessed by asking the person to recall items from their background. For example, a favorite task of interviewers is to ask the person to recall the names of prior United States Presidents, working backwards from the current president until they make an error. One would expect that not being able to recall the name of the president who preceded the current president would suggest the possibility of memory impairment. A similar task is to ask the subject to recall their first schoolteacher’s name and/or their address at the time. Of course one would have to be confident that the person was not confabulating or making the answer up to conceal a memory problem. However, asking the person to recall their social security number and/or their driver’s license number from memory is not subject to this potential confabulation problem, since the answers are easily verified.
Finally, interview data that may not be part of the Mental Status Examination but is obtained during the taking of the person’s history can also provide information about a person’s memory. Thus, if in taking a 45-year-old person’s employment history they tell me that they cannot recall where they worked for four years in their 30’s, I might suspect they have a remote memory problem. In this regard, if they actually do have such a problem then they could be expected to have other similar deficits in recalling historical data. Most frequently, however, such occurrences are found in individuals who do not deem it important to retain such data, or who are motivated to hide some facts about their past. Additionally, one special problem that is encountered in some cases involves true amnesic periods in which the individual tells me that they cannot recall anything from the time they were 4 until they were 9. Frequently, after some amount of investigation this turns out to be a sign of an extremely abusive childhood that has resulted in what sometimes is called motivated forgetting.

VII. **Attention, Concentration and Cognitive Abilities**

Individuals with various mental disorders often have difficulty executing relatively simple performance tests as well as tests of more complex cognitive abilities involving reasoning or thinking. One very simple performance test that is typically used as a measure of attention and concentration requires the examiner to ask the person to count backwards. If the patient is able to perform this task correctly the difficulty of the task can be increased by asking them to count backwards by three’s. If the person is successful at that task they can be asked to count backwards by seven’s. The latter two tasks are referred to as subtracting serial three’s and serial seven’s, respectively. These tests are frequently used as measures of attention or concentration that require a relatively modest level of cognitive abilities. However, the ability to perform them varies with a person’s educational and social background as well as with their intelligence level, so these factors have to be taken into consideration when drawing conclusions from their performance.
Another simple and effective method for assessing cognition, as well as attention and concentration in the context of a Mental Status Examination, is to give the individual various mental arithmetic problems. This task simply asks the patient to solve addition, subtraction, multiplication and division problems without the aid of a pencil or paper or calculator. Generally, the interviewer starts with simple problems that the individual will probably be able to solve, and proceeds to more complex and difficult ones. The decision of where to start is usually based on the individual’s educational and occupational background. What the examiner is looking for is consistency or inconsistency between the individual’s educational and occupational background and other performances in the Mental Status Examination. For example, if the person had already been given an intelligence test prior to the interview and received an average score, one would be very surprised to find them seemingly unable to do simple arithmetic problems. Nevertheless, finding out why this has occurred will usually lead to meaningful clinical information.

A frequently used test that requires and measures a higher level of cognition is an abstraction of similarities task. In this task the person is typically given the names of two nouns and asked to state what they have in common or how they are similar. For example, the two nouns may be “an elephant” and “a whale.” A high level response is “mammal” whereas a somewhat lower level response is “big” or “gray.” An even more demanding cognitive task that is frequently used is the interpretation of proverbs. In this task the interviewer asks the person to provide the meaning of a series of proverbs such as, “A bird in the hand is worth two in the bush.” Whether using proverbs, similarities or other tasks, it is crucial to consider the answers given in terms of the individual’s education, background and socio-economic class. Clearly, what is normal for a Ph.D. in physics, who was raised and educated in the United States, is not normal for an individual with a fourth-grade education who came from a third world country. Only by using what is generally called the psychologist’s clinical judgment, which in turn is based on their experience with multiple individuals, can any credible meaning be attached to the person’s performance.
Still another portion of a Mental Status Examination that deals with a person’s cognitive abilities concerns what is often called their fund of knowledge. Quite simply, how sophisticated or knowledgeable is the person being evaluated? In this area the doctor is mostly concerned with any possible discrepancies between the person’s educational and social background and the knowledge they have at their disposal. As the discrepancy increases, the doctor is more comfortable in concluding that it is due to interference produced by a mental disorder or perhaps by an attempt to simulate dysfunction. Regardless, there are many tests that provide opportunities to collect such data by asking a series of general-knowledge questions. Strub and Black provide one such test composed of 10 questions and indicate that in their experience the average person can answer approximately six questions. On their list are simple questions such as, “How many weeks are in a year?” and more complex questions such as “Who wrote the Odyssey?” Obviously, any such test is subject to the sophistication, education and social background of the person, and again, it is up to the psychologist to use their clinical judgment to determine if any given person’s answers are suggestive of psychopathology or normalcy.

VIII. Major Psychological Disorders

Another area of concern to a doctor administering a Mental Status Examination is the presence or absence of evidence of a major psychological disorder such as Schizophrenia or one of the Bipolar Disorders. As discussed in the section concerning the various DSM-IV-TR disorders, Schizophrenia is characterized by delusions and/or hallucinations and to a lesser extent by disorganized speech or behavior, and on rare occasions, catatonic motor behavior. During the normal progress of a Mental Status Examination no specific tests, questions, or examining techniques are typically needed to determine if the individual has a major psychological disorder unless that disorder is not currently active. If the disorder is inactive, or as psychologists sometimes say, In Full Remission, then the existence of the disorder can usually be determined during the taking of the person’s history or, if that fails, during the reading of their medical records. Regardless, what the examiner in the Mental Status Examination is looking for is any evidence of hallucinations or
delusions. Does the person’s narrative indicate that they appear to be hearing voices or seeing things? Do they express any unusual or bizarre ideas? For example, if a person appears 20 minutes late for an examination and explains their behavior in a matter-of-fact manner by stating that they were late because it was important for them to make sure that the FBI agents that have had them under surveillance for the last month were not able to follow them to the office, then the interviewer should not be at all shy in concluding that this person has some form of a major psychological disorder.

Similarly, if a person comes into the office and begins talking to me about what would normally be a highly emotional event, such as the recent death of a beloved spouse, parent or child, with no, or almost no, appropriate emotions such as grief or loss, then they are said to have a blunted affect and it is necessary to examine the person for the possibility that this is indicative of a major psychological disorder. Additionally, if they are describing the recent loss of a beloved relative and they are laughing or seem to be enjoying the telling of the story, then that inappropriate affect should once again lead to considering the possibility of a major psychological disorder. One would also consider the possibility of a major psychological disorder if the person exhibited a labile affect, or one that varied greatly within a short period of time for no apparent reason. In short, any unusual emotional expressiveness that appears outside of the range of normal human emotions should be viewed as possibly being part of a major psychological disorder.

In a similar manner, if a person talks only about one specific idea and seemingly cannot be steered into discussing other topics, or if they do discuss other things they always come back to the same issue, they are said to have obsessive ideas. At some point those obsessive ideas may turn out to be part of a major psychological disorder. Likewise, if the individual talks about how events described on television by a local newscaster are specifically directed at them they are said to have ideas of reference that are probably part of a major psychological disorder. Additionally, individuals with major psychological disorders also may exhibit paranoid ideation if they talk about having been widely misunderstood and/or mistreated. Alternately, if the person talks about having unwanted or intrusive thoughts that are inserted into their flow of thinking or consciousness,
this is most likely indicative of a major psychological disorder as are cases in which there is a lack of thoughts or what is sometimes referred to as a poverty of thought. Finally, two additional and florid thought abnormalities are the delusional belief that one’s thoughts are being broadcast to others or that someone else’s thoughts are being inserted in one’s mind. Any unusual or bizarre notions or ideas of this nature that come up in the context of the interview process are most likely indicative of some form of a major psychological disorder. Of course, if none of the above appear then it is most likely that the person does not have a major psychological disorder.

An essential part of any psychological evaluation involves the collecting of data that leads to the conclusion concerning the ability of the person to conduct their normal life without any mental disability. Thus, the examiner looks to draw inferences about the person’s ability to concentrate, attend and utilize their memory and other cognitive functions in their everyday life. Do they display any behaviors, thoughts or emotions that would seem to interfere with this ability? Can they understand and follow written and oral instructions in completing the examination or is something getting in the way? Are they assertive and can they make normal requests consistent with their history, or do they appear to have some abnormal difficulties in this area? Do they perform all of the tasks required by the examination in a normal period of time? In an inter-office study of the time it takes people to complete the Minnesota Multiphasic Personality Inventory (MMPI) we found out that those people taking more than two hours to complete the task were most likely to be clinically depressed or suffering from some form of clinical obsessiveness that prevents answering the questions in a normal timeframe. Additionally, other questions to be asked about the interviewees are: Can they form a normal relationship with the interviewer and office personnel? Can they control themselves? Are they overly emotional? Do they appear to be able to draw conclusions from their experiences and make reasonably good decisions? And finally, are they motivated to perform in a socially acceptable and responsible manner? Typically, there are no techniques or questions that the interviewer can use to obtain information about these questions but observations made during the entire clinical interview provide data about these issues.
A Mental Status Examination also provides information about the individual’s social behavior and interactions. Once again, there are no specific questions or techniques that are used to gain these data, but the doctor arrives at their conclusions by observing the patient during the course of the entire face-to-face examination. The data are also obtained from hearing the patient talk about their relationships during the taking of their life history and listening to their current complaints. The questions answered are: Do they have the ability to get along with others? Are there any unusual behavioral characteristics bearing on social relationships? How do they feel about their relationships with others? Do they see themselves as likeable? How are other people likely to relate to them? Do they exhibit any abnormal behavioral characteristics that would likely be disruptive such as depression, anxiety, aggressiveness, compulsivity, over emotionality, distancing, abrasiveness, morbidity, or bizarreness?

Overall, by watching and listening very carefully during the entire clinical interview and by applying some specific techniques and asking some special questions during the Mental Status Examination, the psychologist can form a reasonably good picture of the patient’s status that can then be compared to data collected from the taking of their history, their performance on the psychological tests, a reading of their medical records and interviewing significant people in their lives about their behavior, thoughts and feelings.
Chapter 5

The Life History and Presenting Complaints

I. The Major Questions to Be Answered

While all five sources of data can produce valuable and often extensive information about the patient being evaluated, the person’s life history and their presenting complaints most frequently produce the greatest amount of information. This history can provide the doctor with an understanding of the person’s life experiences and how they have shaped that individual. The history taking also allows for an opportunity to check the patient’s credibility by comparing the information they presented with their testing, medical records, Mental Status Examination data and collateral interviews. Moreover, since the interview typically takes at least two hours, and sometimes four hours or more, there are multiple opportunities to examine the consistency of the information presented within the interview. Essentially, throughout the entire procedure the doctor is asking these questions: What symptoms or complaints does the person have? What in the person’s life led to their current psychological status? Does the person have a disorder? When did this disorder develop? If a disorder is present is it due to the injury claimed? Is the person’s representation of him or herself internally consistent during the interview? Is the person’s representation of him or herself consistent with all of the other data? Clearly, in order to answer these questions it is necessary to obtain a wide variety of data about the person’s life.

II. A Psychologist’s Different Approaches to Normal Clinical and Medical-Legal Evaluations

In a number of places in this book I have made references to the possibility of individuals in medical-legal examinations not being forthright but attempting to present themselves in such a manner as to appear either disordered, when they are not, or more disordered than they really are. As I have indicated, this is not a psychologist’s normal approach to patients or what can be called a normal clinical
evaluation. Typically, in a normal clinical evaluation the psychologist’s approach is to assume that the person that has come to see them has done so in order to obtain some assistance with a psychological problem in their life. Clinical psychologists are trained to take this approach, and they do so quite successfully. However, once external rewards, such as lawsuits and monetary settlements come into the picture, the psychologist must adopt a different attitude. That attitude has to be much more flexible and inquiring and more open in the sense that they have to be aware that what they are being told and what meets the eye and ear may not necessarily be true.

III. Patient Honesty and Plaintiff Attorney Coaching

One major reason for psychologists in forensic situations adopting a questioning attitude regarding patient believability is that there are substantial amounts of data indicating that people will not always tell the truth, the whole truth and nothing but the truth when money is on the line. In fact, it is not always the person being evaluated who comes up with the idea of being a bit disingenuous in search of settlement dollars. In this respect there are multiple publications in professional journals indicating that on occasions, an attorney will coach their claimant about what to say and what not to say during a psychological evaluation. Moreover, there are cases in which attorneys will attempt to coach dishonest performance on the psychological tests. For example, one leading psychologist, Dr. Paul R. Lees-Haley, after reviewing the relatively extensive literature on this topic, concluded that attorneys have a variety of methods for influencing the outcome of psychological evaluations (Lees-Haley, 1997). Specifically, he pointed out that they advise their clients on how to respond to the psychological tests, they make suggestions on what to tell the psychologist during the interview, and they ask their clients not to disclose certain information. In addition, there are reports in the literature indicating that attorneys have been known to advise plaintiffs on the specific signs and/or symptoms of a disorder and to provide clients with money so that they would not have to settle a claim, as well as to tell clients that “it might be worth their while to see a doctor every week” (Rosen, 1995). Additionally, there is information indicating that attorneys coach psychologists “about
what kind of history they will want to take of their client” (Bureau of National Affairs (BNA, 1994). Further, one attorney talked about in the BNA report admitted that she tells psychologists the kind of history she wants them to take. She was quoted as saying, “I tell them what areas I don’t want them to probe.” In yet another example cited by Dr. Lees-Haley a suggestion was made to attorneys to “consider the creation of a symptoms list that you will review with your client on a regular basis” (Lees-Haley, 1997). Apparently, there are multiple smoking guns!

One example of likely coaching has occurred on multiple occasions in my office after I have asked a patient a question only to be told, “My attorney advised me not to answer questions in that area.” Of course, there is nothing that I can do to force someone to answer a question if they really don’t want to, but what I generally do is respond to their comment in the most direct and honest fashion possible. I simply say to the patient, “Mr. Jones, I certainly can’t force you to answer any questions that you don’t want to answer, and if you don’t want to give me the information I have asked for, please, keep it to yourself. However, in all honesty, I am supposed to take a complete history from you, which requires me to ask questions about the area you have just told me you have been asked not to discuss. Therefore, in order to demonstrate that I am doing my job properly, I will simply put into my report that I asked the question but, on what you said was your attorney’s advice, you declined to answer.” It is a very rare patient that will not subsequently answer all of the questions I ask.

IV. The Major Sub-Sections of a Life History

There are 14 major sub-sections to this portion of the medical-legal report. Essentially, this section details all of the relevant events in the patient’s life. It follows the person from birth to the time they walked into my office. Overall, while it is possible, it is difficult to include too much of the information in a medical-legal report. When in doubt, the rule I’ve always followed is to include in the data. Also, at times I find myself presenting the same information, often in a slightly different way or context, in more than one place in the report. This is not an error. Especially with important pieces of information, it
is sometimes better to be redundant than parsimonious. This is because redundant information is not as likely to be missed as data that is only inserted once. Since report readers initially often skim them rather than read them, especially when they are 50 or more pages long, if crucial information is presented more than once it is less likely to be overlooked.

The 14 major sub-sections describing the person’s history and complaints are:

1. Places of Residence
2. Marital History
3. Family of Origin
4. Education through Junior High School or Middle School
5. High School Education
6. College Education and Any Other Formal Educational Experiences
7. Employment History
8. History of the Injury
9. Current and Past Complaints
10. Medical History
11. Substance Use History
12. Psychological Treatment and/or Evaluations
13. Miscellaneous Personal History
14. Current Activities

1. **Places of Residence**

   This paragraph traces the patient’s movements from their place of birth to their current residence. Usually it is sufficient to provide the cities, states and dates of residence for every place the patient has lived. The paragraph concludes with where they are currently living, including mentioning with whom they reside and the nature of their relationships with those people and the type of domicile.
a) The Relevance of Gaps in a Patient’s History

It is very important not to have any gaps in this history since those gaps may be correlated with other important events in the person’s life that may have been inadvertently or deliberately left out. For example, let’s say that the patient lived in Ohio between 1984 and 1986 and that they suffered a work-related psychological injury that they wished to disown. They may deliberately leave out both the employment history and the residence history in an attempt to avoid providing potentially litigationally damaging information. Unless the person is very sophisticated and creates a false history, they most frequently simply say they “don’t recall” what they were doing during those years. Often by asking the question in a different way or coming back to the issue by a different route, say in taking a medical history, that information will frequently be “recalled.” Regardless, by making sure there are no gaps in the person’s history, the psychologist is enhancing the odds that any deceptions will be detected.

In addition to making sure that there are no gaps in the person’s history, it is very important that the residence information be consistent with the information found in other places in the report. For example, it is not acceptable to say that the patient has lived their entire life in the Los Angeles area, and then later in the report say that between 1991 and 1994 they worked in Houston, Texas, unless there is also history indicating they commuted between the cities. Similarly, it is not acceptable to say that the patient lived their entire life in California but attended the University of Montana in Missoula from 1972 to 1976. While these discrepancies may be meaningless with regard to determining if the person has had a psychological injury, they can be very meaningful with regard to the credibility of the psychologist’s report. Specifically, any inconsistencies found in a doctor’s report questions its credibility and can be used by opposing counsel to create doubt about the remainder of the doctor’s data as well as their conclusions. In fact, that is the opposing counsel’s job. In this regard, it is my understanding that these inconsistencies result in the psychologist getting hoist on their own petard at the hands of a common legal principle, “Falsus in uno, falsus in omnibus. False in
one thing, false in all.” In fact, the best way I know of avoiding this happening is to imagine I am under cross examination by the opposing counsel as I write my report.

b) Correcting Mistakes in History Taking

The best way for me to avoid errors in consistency is to make sure that during the interview of the patient I check for consistency between where the patient said they worked and were educated and where they said they lived. Patients will frequently provide conflicting information, and once they leave the office there is little I can do. While it is tempting for doctors to think that it is a good idea to call the patient and attempt to clarify inconsistent information, experience has shown that attempts to do this are likely to lead to the patient telling their attorney of the phone call and the attorney attempting to and possibly succeeding in getting a report thrown out of court because the doctor “harassed” the patient. At best, such behavior creates doubt about the accuracy of the rest of the doctor’s history and their conclusions.

2. Marital History

For each of the marriages that the patient has had I write a separate paragraph in the report describing the nature of the marriage as well as the type of person they were married to and the circumstances and cause for the relationship ending, if it has ended. It is also important to treat any relationships where the patient lived with another person in a romantic or intimate partner relationship for any length of time as if it were a marriage. By taking a complete history of a person’s intimate relationships one can obtain essential details of their psychological nature. In some cases I will find data indicating that the person is a highly dependent and relatively psychologically weak person who is more likely to develop a disorder when placed under stress than someone who is more independent and stronger. Likewise, in some cases I will find that in discussing their relationships I discover psychological strengths that make it less likely that the person would succumb to a psychological stressor. Once again, the basic rule in all history taking, and for that matter in
all data collection in a psychological evaluation, is to obtain as much information as can be reasonably collected.

In addition to taking information about the person’s marriages and significant relationships it is important to find out about all their children and the relationships they have with those children. As all parents know, having and raising children can be a stressful experience even under the best of circumstances. Clearly, it is even more stressful if there have been one or more children in the family with special problems in education, legal, psychological or medical areas, since these may have significantly affected the patient’s ongoing level of functioning and made them more vulnerable to the stressor that brought on the current claim. As I have pointed out previously, as a general rule it is not only important to find out if a person has a psychological disorder, but why they have that disorder and what has affected it and its resolution.

With divorce rates accounting for about half of all marriages, it is common to find parents living with children that are not their own as well as having their biological offspring living with others. Since these types of relationships often have their own special problems it is important to note when a child has not been living with their biological parents and what their relationship is with the child not under their complete custody. Similarly, it is important to note what has occurred when a new primary relationship has been entered into and children brought along. These relationships may identify other sources of stress and may also reveal additional aspects of the individual’s personality.

Finally, on occasion patients will decline to present data about a child who has died. This is obviously understandable and quite important in taking a history, especially if the death occurred relatively recently. Returning to the notion of the honesty of the patient, I have interviewed people who have completely denied the existence of a recently deceased child. While this may simply be their way of coping with grief by attempting not to talk about a painful experience, it may also be an attempt to deliberately conceal information that may be relevant to their claim. This is especially true for individuals claiming a clinical depression, since grief or bereavement often have the same signs and/or symptoms as a clinical depression.
3. **Family of Origin**

Some psychologists believe that all important psychological events occur before the age of five, or to put it another way, anything in the environment that is psychologically going to shape a person is likely to have happened by they time they are five. Once having accepted this premise, it is easy to understand why it is important to obtain information about the person’s family of origin. Of course, most adults will rarely remember what occurred to them at an early age. However, it is possible to obtain significant information about their likely early experiences by taking a careful history of their parents and their relationships with these individuals. When doing so, it is relevant to find out what went on in the home at various stages in their lives as well as what goes on in the present. Essentially, as a psychologist, one works backwards and tries to determine what the person’s early experience must have been from what they say about what they can recall.

One highly relevant issue that frequently is found in cases in my office is childhood abuse, both physical and sexual. While there are no hard data on the issue, it appears very likely that cases of childhood physical and sexual abuse occur much more frequently in individuals who are sent to my office for an examination than in the general public. It seems virtually inescapable to conclude that in comparison to the general public these people are more vulnerable to stressors and are more likely to have had a psychological disorder before the stressor that is claimed to have produced a psychological injury. In essence, when evaluating people such as these the key to the case often lies in partitioning out the problems due to the claimed event from all of those problems having nothing to do with that event.

In the most general sense the interviewer must be on the lookout for information about the nature of the treatment that the child received in their family of origin, since that is often highly related to their adult adjustment. Unfortunately, a very large percentage of the people that I evaluate come from abusive families. Extreme physical and multiple sexual abuse of the patients during their childhood is not an unusual finding. Very often the abuse comes from an alcoholic father. At times it comes from an alcoholic mother. Drug users who are parents also frequently abuse their children. Finally, child abuse
is frequently a result of mentally disordered parents who seemingly, at times, have nothing to do but vent their problems and frustrations on their children by hitting them with a wide variety of objects and/or maltreating them in a variety of ways that I do not enjoy hearing about. Nevertheless, this information is relevant since it often provides data that is important to the diagnosis of a Personality Disorder that may not be entirely apparent in the Mental Status Examination and the remainder of the clinical interview. It is a wise examiner who is always on the lookout for abusive parents and siblings as well as other family members such as uncles, cousins and grandparents.

As we have seen, in the case of multiple parental marriages it is important to describe all of the “parents” and the patient’s relationship with each one. The exception to this is if one or more of the patient’s parents was married prior to the birth of the patient. Then it is often enough to get a name, if they have it, and to ascertain if there were any children of that union or multiple unions with whom the patient has contact. Frequently one finds that the patient is quite friendly with half siblings from a prior marriage even though they did not know their parents’ previous spouse. When such a relationship exists it is important to obtain information about those half siblings as if they were full siblings.

At times, I also find that I see patients who were not raised by their biological parents but by uncles, aunts, grandparents or friends of the family. When this is the case, I must describe the biological parents as best I can with the limited information I am given and then go on to discuss the nature of the relationship between the person being evaluated and their biological parents. Of course it is also important to then go on to examine the relationships between the patient being evaluated and the person(s) responsible for raising them. Additionally, patients who were raised by adoptive parents require that I obtain whatever information they have about both their biological and adoptive parents. Although most frequently they will have no information about one or both of the biological parents, it is important to have this complete history since some psychological disorders have a genetic basis.
4. **Education through Junior High School or Middle School**

This portion of the patient’s history, and the corresponding section of the report, not only describes what the patient was probably like in grammar school, but it also describes what their family life was like. It clearly overlaps the data obtained and discussed in the previous section on the Family of Origin. This is by design, as the information obtained at different times during the interview and history taking is used to check for internal consistency. For example, early in the interview the person may not tell me that they were raised by abusive parents. However, in describing their psychological status while in grammar school they will refer to themselves as “unhappy” and go on to describe the reason for this as a physically and verbally abusive alcoholic father who attacked everyone in the family. This major inconsistency needs to be clarified by additional interviewing. What I am looking for is the best estimate of the truth.

The issue of academic achievement is quite important because it should be consistent with the remainder of the person’s history and behavior. For example, if the patient tells me they performed at a high level in school but never lived up to that performance in the job market, this is a red flag. Was the school performance really that high? If so, why the underachievement in the workplace? Once again, everything I am told by the individual must fit in with a consistent picture of who they are and how they got to be that way. To do any less is not to have an understanding of the patient, a certain fatal flaw in any evaluation and one that will not hold up to the rigorous inspection of the legal system.

Special problems with dealing with an individual’s educational background arise for people who were educated in different countries. In particular, in California a large proportion of the population was educated in Mexico or in various other countries south of our border. With these individuals it is not unusual to have bright people with limited education, occupational underachievement and poor cognitive testing skills. Clearly, their poor performance at work, and on tests of their skills in the doctor’s office, may mean something very different than for someone who has the same
underlying abilities but has completed a reasonable amount of education in the United States.

5. **High School Education**

   The high school years are obviously important as this is when the patient makes the transition from childhood to adulthood. In taking this history I am looking for a general picture of what they were like. Did they graduate? Did they like school? How well did they do in their classes? How did they relate to their peers? What were their friends like? What did they do with their spare time? How did they adjust to new sex roles? Since Personality Disorders typically occur no later than early adulthood, I am looking for patterns of behavior that might suggest such a disorder. Of course, I am also looking for the presence of normal behaviors that would let me rule out or eliminate Personality Disorders as well as other disorders that might likely have their roots in adolescence. Once again, taking this portion of the person’s history gives me further understanding of their psychological nature and provides a basis for insight into their current status.

6. **College Education and Any Other Formal Educational Experiences**

   In this section of the report it is important to present information obtained about the individual’s college education and/or any other formal education that they might have obtained after high school. If nothing else, this will help account for the individual’s time and give me an indication of their normal cognitive, emotional and behavioral skills. In particular, this information is used to provide data about the credibility of a person’s complaints. For example, if the person has a relatively low performance on cognitive tests on the Mental Status Examination and presents with classic signs and/or symptoms of a clinical depression, but has a relatively high level of education, this supports the conclusion that they are suffering from a clinical depression. Similarly, if the individual has the same high level of education but presents with a very low level of occupational accomplishments, this supports the notion of some pre-existing
psychological issues that have led to underachievement. As always, the individual being evaluated is probably best approached as a puzzle in which all of the pieces must fit into a cohesive picture. Obviously, the more data collected or pieces of the puzzle to be dealt with, the tougher the job for the psychologist. However, the more data that can be put together into a cohesive picture, the stronger and more credible the report and the conclusions.

7. **Employment**

In this section of the report it is important to provide information about every place the individual has ever worked, including any part time jobs they had in high school. There should be absolutely no gaps in the history. If the individual states that they did not work for five years between 1982 and 1986, fine! I just say so. At that point I simply note what they said they did during those years. If the individual states they do not recall where they worked or what they did between 1982 and 1986, fine! I just say so. It is clearly not the doctor’s responsibility to account for their whereabouts or their activities over the years. However, it is the doctor’s job to ask the questions and to make sure that the history provided by the patient is as consistent as the person can make it. Additionally, with regard to the person’s job history it is very important to obtain information about their psychological history at their places of employment. Thus, I want to know such things as how they got along with others, including their relationships with supervisors, supervisees and co-workers, and why they left each job. Information along these lines will provide baselines for drawing conclusions about the person’s normal levels of functioning. With those baselines in mind I can then assess the person’s current occupational functioning, looking for signs of any possible decrements that might be due to a psychological disorder and indicate if the person has had a psychological injury and a psychological disability.

Especially in cases where there is a claim of a psychological injury that is due to a physical injury that occurred at work, it is relevant to determine if there have been other such physical injuries in the workplace. It is also important to find out if there have been other such physical injuries that have occurred outside of the
workplace. If the person has developed such a psychological disorder as a result of repeated physical injuries to the same physical system, it may be relevant for the court to consider the psychologist's opinion as to the relative roles played by each of the different physical injuries in developing the psychological disorder found at the time of the examination.

8. **History of the Injury**

In workers' compensation injuries it is important for the psychologist to obtain as much information as they can about the person’s employment at the place where they were injured. This is so that they can place the injury, and how it was handled, in a context. Accordingly, in taking the person’s injury history, it is best to start with when they were first hired and proceed to the date they last worked, obtaining information about all of the positions they held, including any promotions or demotions. Along the way it is relevant to find out about their salary and/or wages, work hours, location of employment, supervisors and anything else that can be learned about where they worked. It is also important to find out some information about the nature of the company's business, i.e., what the company does. Similarly, it is very important to obtain their job title at the time of the injury and specifically what they did at work. That is, get a good description of their job duties.

a) **Two Different Kinds of Psychological Injuries**

Psychological work injuries fall into two classes: those caused by a physical injury in which a psychological disorder developed as a result of that physical injury, and those caused by purely psychosocial events.

b) **Physical Injuries Leading to Psychological Injuries**

In this case there may have been a fall that led to a back, neck, leg or arm injury. Typically, if the treatment and recovery have been uneventful the person does not develop a secondary psychological
injury. However, in cases where the recovery from the injury was not what one would have preferred as a result of complications, unsuccessful treatments or a catastrophic injury, there frequently are secondary psychological disorders. In many of these cases the individual is unable to go back to their normal and customary occupation and is not well prepared to re-enter the job market in another capacity. In cases where the injury occurred at work, rather than in a non-work environment, there are benefits provided to the injured worker by the workers’ compensation system that may not be sufficient to make the individual whole. Thus, in some of these cases there are severe economic problems and/or family problems produced either by the physical injury itself, the concomitant unemployment, or the adverse psychological reactions to the incapacity or unemployment. Most frequently these individuals develop depressive or anxiety disorders. There are also cases in which there have been pre-existing disorders that may have been exacerbated or aggravated by the industrial injury or what the court may determine are non-industrial factors. Only with a thorough and comprehensive report, a large part of which rests on the doctor’s history, is it possible to draw conclusions about the nature and cause of the person’s psychological status.

c) Psychological Injuries as a Result of Psychosocial Events

In many other cases industrial injuries are produced by purely psychosocial events. These injuries also may occur off the job such as when the person is in an automobile accident or perhaps was a victim of a crime. Often these psychological injuries produced by psychosocial events are called “stress injuries” or “pure stress injuries.” In fact, the term “stress” is often of little use in psychology as it has so many meanings that without a great deal of discussion the term is ambiguous. For example, if one talks about “stress” it is sometimes unclear if one is talking about an actual event that occurred in the environment, the person’s conscious response to that actual event or their physical response. When a person comes into my office and reports that they have been a victim of “stress,” that is only the beginning of the conversation. Clearly, what needs to be done is to find out exactly what they mean by “stress.”
Overall, there are a wide variety of adverse psychosocial events that can produce psychological disorders. For example, all of the following have been known to produce psychological injuries: traumatic accidents that have simply been witnessed, traumatic accidents with no physical injury, robberies at places of employment, sexual harassment, racial harassment, religious harassment, interpersonal difficulties leading to harassment for no other reason than one person simply does not like another, interpersonal incompatibility, unlawful terminations, changes in working conditions, and undesired occupational transfers. It is impossible to predict that any given event, no matter how horrendous or traumatic, will produce a psychological disorder. There are people who have been through some tremendously traumatic events, such as being held hostage for a long period of time or being exposed to horrific war experiences, who seemingly have been no worse off as a result of what occurred. On the other hand, there are people who have had seemingly minor interpersonal difficulties that have left them shattered. Often the psychologist can piece together why one person will react one way and the other quite differently. However, in many cases there is no completely clear answer, although there may be statements that can be made about what “probably” happened or what was “likely” the cause.

In cases where there are claims of a psychological disorder due to interpersonal events or harassment, it is obvious that it is not the psychologist’s job to determine who is right and who is wrong, if there is a right and wrong. Furthermore, it is usually impossible to determine what actually happened, since the psychologist typically gets to hear only one side of the story and the documentation of what has occurred is usually non-existent or weak. All that one can do is get as complete a history as possible, draw the best conclusions that can be drawn from all of the available information, and allow the court to do its job of sorting out what occurred and what is true. That is why psychologists who do this work are paid for their expert “opinions” and not their expert “certainties.” In fact, according to the basic legal notions of causality, all that a doctor can do is come up with a conclusion as to what is “reasonably medically probable.”
9. Current and Past Complaints (Symptoms)

As previously noted, when a doctor observes something that is wrong with a patient, the doctor states that they have observed the “signs” of a disorder. However, if a doctor refers to the patient’s “symptoms,” that doctor is not referring to anything that was directly observed other than the patient complained about there being something wrong. “Symptoms” and “complaints” are synonymous in psychology and related disciplines, although even some professionals incorrectly use the terms “symptoms” and “signs” interchangeably. To avoid this confusion, whenever possible I avoid the word “symptoms.” Instead, I talk about a patient’s “signs” when there is something I have directly observed about the patient, and then I use the word “complaints” to describe what the patient has told me they believe is wrong with them.

In taking a history of a patient’s complaints it is necessary to find out what they believe was wrong with them from the time they were hurt until the day of the evaluation. In this regard, I have found that it is best to work backwards and first find out what is currently wrong. In taking the patient’s history of those current complaints I am likely to say something like, “Ms. Smith I would like to get a complete list of all of your current complaints. And by “current” I do not just mean at this moment, but any complaints you have had in the last month. After we make the list then we will go back and discuss each of them. Also be sure to tell me about all of your complaints, both physical and psychological. It is important that we do not miss anything.” I then proceed to make a complete list of the patient’s complaints and after having done so I am likely to say the following, “Ms. Smith, you’ve now told me everything that is currently wrong with you, but sometimes people forget things so if at any time in this interview you think of anything else, please be sure to add it to our list.” In this way there is very little chance of having missed any complaints as a result of my not giving the patient enough time to recall things that may be present but are not very prevalent or serious.

Once having obtained the list of complaints, I then go over each complaint with the patient asking them to describe the qualitative nature of each one and then the frequency, intensity, duration and
onset of those complaints. So if, for example, the patient told me that they get headaches, I will ask them to describe what it feels like when they get a headache. I will also ask them to tell me how often they occur, when they started and generally how often they last. I will also acquaint them with a ten-point rating scale that has been devised for rating things like pain, which asks the person to assign the number 1 to a minimal amount of pain that would be present if there was just barely a noticeable amount of pain, the number 10 to the most intense pain they can imagine, and the numbers in between to various degrees of pain. Of course the same scale can be applied to psychological complaints such as depression, with 1 being the least noticeable amount of depression and 10 being the worst depression they can imagine. Since pain and depression are subjective experiences, having the person rate those experiences is the best we can do with regard to quantifying the intensity of the experience.

Then, having collected all that data for the complaint of headaches, I will move on to each complaint on the list until the list is exhausted. Finally, to make sure that the patient has told me everything they can recall, I’ll say something like the following, “Is there anything else that has been bothering you in the last month that we haven’t talked about?” If the patient’s response is positive I’ll take the additional history and again ask them for additional complaints. Double checking and triple checking is a form of bending over backwards to make sure that I don’t miss anything.

Having obtained a history of the patient’s current complaints the next task is to find out about any complaints that may have been present at sometime after the injury but have dissipated or gone into remission. At this point in the interview I will simply ask the person to tell me if they have had any complaints that began after the injury and have gone away. If there are any such complaints I will list them and find out what they were like, that is, how they were experienced or felt, when they began, when they went away and their frequency, intensity and duration. Obtaining this history may take a considerable amount of time and patience since for longstanding resolved complaints they may have gradually gone away over a period of time, or have come and gone on more than one occasion, complicating the history taking. However, without a complete history it is not possible to understand the patient and come to any credible conclusions.
It is normal procedure in my office to administer, score and tentatively interpret the battery of objective psychological tests prior to the interview. At times, when the testing data point in a direction that leads me to suspect that a patient may not be completely honest and straightforward, I may take portions of the person’s history on two occasions during the interview and compare them to see if they are consistent. When this is done, on the first occasion I simply get a listing of the complaints without collecting any data on their supposed quality, frequency, intensity, onset or duration. Then perhaps an hour later in the interview I’ll ask the person to provide me with the same list of complaints. Clearly, if the lists are more than trivially different the suggestion is that the person may not be giving me a complete and honest accounting of what is wrong.

As noted earlier in my discussion of the Mental Status Examination, before any data are collected from a patient undergoing an examination they sign an informed consent statement. This simply states that the person understands that they are in my office for a psychological evaluation in conjunction with a psychological injury occurring as a result of what is specified in their claim. The statement also clearly indicates that the information that they provide me is not confidential and that I will write a report concerning their psychological status and that that document will go to the attorneys on both sides. Despite the person knowing that they are being psychologically evaluated, on some occasions I have found that an individual will not have any psychological complaints during the interview. In short, I will go through the entire history taking described above and will not hear of a single psychological complaint. Clearly, this may be a function of there not being anything psychologically wrong. In these cases, I will very explicitly say, “Ms. Jones we’ve talked about a series of things that are currently bothering you. Is there anything psychologically wrong with you at this time, or has there been anything psychologically wrong with you since the date of your injury?” At this point some people will simply say “no” to both questions. Some of these people will go on to report that their attorney sent them for an examination and they have no idea why but are simply following directions. Others will then “recall” that they have been severely depressed for some time but will be unable to provide any cogent answer as to why they did not provide this history. When this happens, it is usually the case that the patient
has nothing psychologically wrong with them, forgot to make the complaints consistent with their claim, and is simply covering their tracks.

In some of the cases in which the person has told me that they do not have any psychological complaints and never had any in the past, there may be medical records indicating that they have been evaluated and/or treated by a mental health professional. At other times the person will indicate on an information form given to them shortly after arriving at my office that they have seen a psychologist for an evaluation and/or treatment. When this occurs I may say, “Ms. Jones, I see that your attorney sent you to Dr. Smith for some psychological consultation or treatment. Ms. Jones, why did you go to Dr. Smith?” At times they will tell me that they simply went “because my attorney sent me.” Of course comments like these are most consistent with a person who has not had a psychological injury.

10. **Medical History**

a) **Separating General Medical Conditions and Psychological Disorders**

The importance of taking a complete medical history in a psychological examination is, in part, required by the difficulty in distinguishing between (a) mental disorders that are due to a general medical condition and not psychological factors, (b) psychological disorders that present as medical conditions but the person’s signs and/or symptoms cannot be explained by a medical illness, and (c) medical conditions that may be affected by psychological factors. These three different possibilities are discussed below.

(1) **Mental Disorders That Are Due to a General Medical Condition and Not Psychological Factors**

There are many psychological disorders that are directly produced by general medical conditions. These were discussed at length above under the general heading of Mental Disorders Due to a General Medical Condition. Included in this category are an Anxiety
Disorder Due to a General Medical Condition (293.89), a Mood Disorder Due to a General Medical Condition (293.83), a Personality Change Due to a General Medical Condition (310.1), and a variety of Sleep Disorders Due to a General Medical Condition. Mental Disorders Due to a General Medical Condition are characterized by signs and/or symptoms of a psychological nature that are due to the direct physiological consequences of a general medical condition. There are many general medical conditions that can directly produce a mental disorder such as central nervous system neoplasms, head traumas, cerebrovascular diseases, epilepsy, human immunodeficiency viruses, endocrine conditions, and lupus. Probably one of the best known conditions of this nature is hypothyroidism. Hypothyroidism is a deficit in the hormones produced by an under active thyroid gland that can cause the individual to have multiple complaints, one of which is clinical depression. From the point of view of an endocrinologist, individuals who present in this manner do not have a psychological disorder but an endocrinological disorder, and when treated by an endocrinologist will relatively rapidly become asymptomatic. Similarly, if misdiagnosed and treated with psychotherapy, their signs and symptoms will persist until treated with medication.

(2) Psychological Disorders That Present as Medical Conditions But The Person’s Signs and/or Symptoms Cannot Be Explained By a Medical Illness

In contrast to the above, there are a variety of psychological disorders called Somatoform Disorders that were discussed above under that general heading. Somatoform Disorders are characterized by the presence of physical signs and/or symptoms that suggest that the individual has a general medical condition accounting for their signs and/or symptoms but in which those signs and/or symptoms cannot be fully explained by the general medical condition, the direct effects of a substance or another mental disorder. Essentially, the person presents with medically unexplained physical signs and/or symptoms and there is reason to suspect that their complaints are due to psychological factors or variables and that the individual is not faking or Malingering (V65.2). The most frequently diagnosed Somatoform Disorders are: a Somatization Disorder, an
Undifferentiated Somatoform Disorder, a Conversion Disorder, Pain Disorders, and Hypochondriasis.

(3) Psychological Factors Affecting a Medical Condition

Finally, it is also well known that psychological factors, problems or variables can influence the expression of medical illnesses. In fact, there is a special DSM-IV-TR category for this occurrence called Psychological Factors Affecting a Medical Condition. This is not a disorder but a condition that sometimes comes to the attention of a mental health professional and may require counseling. In order to specify this condition correctly it is necessary to show that one or more psychological factors or variables are affecting a person’s medical condition.

As noted above it is important to take a complete medical history in a psychological examination in order to attempt to establish the relative roles played by general medical conditions and psychological variables in producing what appear to be general medical and psychological signs and/or symptoms. As we have seen, general medical conditions can produce psychological disorders and psychological factors can affect a person’s medical condition as well as produce psychological disorders that, at first glance, appear to be general medical conditions, but are not.

Additionally, a person’s medical condition can positively or negatively affect their psychological status without actually producing a disorder. Perhaps this most frequently occurs in individuals who are chronically ill or have an acute illness that is affecting their psychological well-being without actually producing a psychological disorder. For example, a person may be depressed but may not have a diagnosable psychological disorder because their reaction to their physical illness is a normal, expectable, reasonable and/or understandable reaction to what has occurred. Imagine for a moment that you have been unexpectedly told that you have a life-threatening medical illness. Getting depressed as a result of finding out about your situation is well within the normal range of human experience and not indicative of a psychological disorder.
Given the above, it is understandable that in order to find out about a person’s psychological status it is important to obtain information about all the medical illnesses that the person has or has ever had. As the amount of information one can obtain regarding these illnesses increases, the more confident the psychologist can be in understanding the person’s psychological condition. Thus, it is normal procedure to ask and report about all of the patient’s current and past medical illnesses. In doing so it is important to obtain a complete history of the symptoms of each such illness as well as a complete history of the medical professionals who treated the patient, including the nature of the treatment, such as medication, surgery, physical therapy, chiropractic manipulations, and acupuncture. It is also quite important to get a complete history of all of the patient’s current medications as well as who prescribed them and the patient’s compliance with the medication regimen, since some prescription as well as non-prescription medications are known to have adverse psychological consequences. A complete medical history also involves obtaining data about all surgical procedures the patient has undergone as well as all hospitalizations for whatever reasons. Clearly, information about all accidents requiring medical treatment is important, as are data about the person’s routine medical care, including information about who provides that care and the nature, date and results of the most recent examination. Only when one can understand the patient’s physical health is it possible to obtain a complete understanding of their psychological status and the possible reasons for the occurrence of any psychological problems.

11. Substance Use History

In attempting to arrive at a definitive psychological diagnosis it is important to explore the possibility that the person being evaluated has a substance use disorder. Clearly, in order to achieve this goal it is necessary to take a complete history of their use of both legal and illegal psychoactive substances. In many cases individuals undergoing psychological evaluations in conjunction with personal injury or workers’ compensation litigation will be reluctant to provide a complete history of their substance use, perhaps believing that it is irrelevant to their claim, an invasion of their privacy and, somewhat correctly, that it will adversely affect the outcome of their litigation.
Accordingly, it is not unusual for a person to provide a complete denial of having used or abused substances, only to find evidence to the contrary in their medical records. Nevertheless, the interviewer needs to ask the questions. Thus, it is important to take a complete history of the patient’s possible use of alcohol, marijuana, heroin, pills not prescribed by a physician for treatment or prophylactic purposes, cocaine, hallucinogens, caffeine and nicotine. Obviously, it is also important to obtain a history of any outpatient or inpatient drug treatment. Since the major purpose of all psychological evaluations is to understand the person, it is not possible to do so without a complete history, including that of substance usage.

12. Psychological Treatment and/or Evaluations

It is obvious that since the main issue for the psychologist is the patient’s psychological status, it is crucial to obtain a complete history of each and every mental health professional that they have had professional contact with during their entire lives. For each such professional it is important to obtain their name, professional identification, their location, the dates of evaluation and/or treatment and any information the patient may have on the disorder or disorders they were being treated for. In many cases the information obtained will be minimal. However, if the professionals can be identified by name and location, the attorneys in the case can obtain those records, which can be reviewed at a later time and may provide information that can reinforce or change one’s conclusions.

Additionally, in the case of a prior examination in conjunction with the current litigation, it is important to obtain information about the conditions of that evaluation. While it is expected that all professionals conducting evaluations in medical-legal cases would act in a thoroughly professional manner, this, unfortunately, is not always the case. One of the very first cases I worked on more than twenty years ago taught me how important it was to obtain these data. Without any undue suspiciousness I interviewed the patient I was examining about her experiences in another psychologist’s office. I asked her such routine questions as: How long was the evaluation? What kinds of questions did the doctor ask? Were you interviewed by anyone besides the doctor? What kinds of tests did
you take? When it came to asking about the psychological testing
the woman revealed that she had been given the MMPI. She noted
that it was the same test that I gave her in my office prior to my
interview. However, she gratuitously added that the other doctor
“was nice enough to let me take the test at home.” She went on to
say that she took the test in her dining room and that she and her
daughter “voted” on how to answer the questions and had a very
enjoyable and amusing evening talking about the possible meaning of
each question before deciding on their answers. Obviously, this
doctor’s procedures totally invalidated the testing data, as the MMPI
testing manual very explicitly states that the patient is to take the test
under conditions in which there is the presence of an examiner or test
proctor and a quiet room with adequate lighting and ventilation
(Hathaway & McKinley, 1983). Of course, I wrote exactly what I was
told by the patient and later learned that the doctor’s report was
thrown out of court.

13. Miscellaneous Personal History

In addition to all of the above, there are other sources of
information that the patient can provide that are relevant to
understanding their psychological status. In this regard, I routinely
take a history of any military service, prior litigations, financial
circumstances including current and past business ownerships and
possible bankruptcies, a legal history of the patient and their close
family members including any possible arrests, convictions and/or
incarcerations, criminal victimization of the patient and close family
members, and recent deaths and/or serious illnesses of friends and
family members. All of these questions are aimed at finding out if
there is anything unusual going on in their life at the current time or in
the recent past. Again, if anything positive comes up, such as an
arrest record, the more information I can obtain the more likely it is
that I can fully appreciate the individual’s psychological status. While
asking these questions may appear to be an invasion of privacy, once
the individual places their psychological status at issue in conjunction
with a claim or a lawsuit, no such privacy exists and it is my job to
take a complete psychological history. Thus, although the person
does not have any obligation to answer the questions, it is my
responsibility to ask them and record the answers.
14. **Current Activities**

One of the best ways to find out if a person currently has a psychological disorder is to find out what they are currently doing. I always ask the person to describe a typical weekday in their current life, a typical Saturday and a typical Sunday. I listen to what they say they do from the time they get up until they go to sleep. Clearly, if a person is anxious, depressed or has any other psychological symptoms they will behave consistently with those symptoms. For example, I can expect a person who is clinically depressed to be fairly immobile. They may tell me that they watch television all day. They most likely will not describe an active life, working, going to school, interacting at length and depth with their family or working on their hobbies. On the other hand, if a person is not disordered I can expect them to provide a history of engaging in their normal activities. These data can then be compared with information obtained during other portions of the history taking as well as other data sources such as the patient’s medical records.

As with almost everything else in the evaluation, I look for consistency. As the examining psychologist, during the early to middle stages of the examination I develop a hypothesis or an idea of what is wrong or right with the person and then test that hypothesis during the interview by collecting historical data. If I obtain information consistent with my hypothesis I continue to have confidence in that notion. If I obtain information inconsistent with my hypothesis, then I simply change my hypothesis to fit the data and continue to recheck my new idea against additional information. However, regardless of where the information leads me, I work on developing an idea of what the person is like based on the information I am given. When I get information from the patient that is internally inconsistent I attempt to resolve the inconsistency by obtaining more data. I then use those data to change my ideas about the person. If the inconsistencies cannot be resolved, say if a person complains that they are severely depressed but gives a history describing behaviors inconsistent with depression, I will likely report that, and more likely than not, conclude that the person was not being honest and straightforward during the examination.
Chapter 6
The Psychological Testing

I. Objectivity and Standardization

One of the five sources of information used in psychological evaluations is psychological testing. Ideally a psychological test is an objective and standardized sample of behavior that can be used to draw generalizations and inferences about a person’s psychological status. Objectivity in psychological testing can be contrasted to subjectivity. A test is objective if the person administering and/or interpreting the test does not allow any of their feelings, thoughts, or ideas into either the administration and/or the interpretation of the test’s data or results. For example, a test is said to be objective if the same results would be obtained and the same conclusions drawn regardless of who the person was who administered the test and regardless of what thoughts, feelings, attitudes or ideas that person brought to the testing situation. In contrast, a test is said to be subjective if the person administering and/or interpreting the results has feelings, thoughts and attitudes that work their way into the process and influence the interpretation of the test’s results and the conclusions being drawn about the person being tested.

Subjectively interpreted tests are inappropriate for use in medical-legal evaluations for a number of reasons. First, since the interpretations are the product of a subjective process they do not yield objective data that can be presented to the court for public inspection, verification and discussion. Second, as the product of subjectivity there is no way of keeping any possible client bias that may enter the process from influencing the conclusions. While it is tempting to consider doctors above the fray of litigation, they are nevertheless human and not immune from perceiving things in a manner more favorable to their clients than the highest level of professionalism would warrant.

As the above discussion indicates, psychological testing is only meaningful if the results and interpretation of the test’s data are the same regardless of who administers and interprets the test. In order
to accomplish this goal, useful psychological tests are always standardized. First, a test is said to be standardized, and to produce a standardized sample of behavior, if the instrument is administered in a uniform manner. In order to accomplish this end, all of the conditions that could conceivably affect the outcome are known and controlled so that who gives the test and where it is given does not affect the results. Obviously, this is very important in psychological evaluations, since a test’s results can only be considered meaningful to the readers of an evaluation if they can assure themselves that those results would be the same regardless of who gave the test and where it was given. Thus, when Dr. Jones said that he gave Ms. Brown a specific standardized test and she received a score of 12, when Dr. Smith reads that report Dr. Smith can reasonably assume that Ms. Brown would have received the same score if he administered the test and therefore Dr. Smith can count on that score as being the same as it would have been if Ms. Brown was tested in his office. Compare this with a situation in which Dr. Jones and Dr. Smith did not use standardized procedures. Then, if Dr. Smith read Dr. Jones’s report, Dr. Smith would have absolutely no idea if the findings reported by Dr. Jones would be the same if he tested Ms. Brown in his own office. Under these hypothetical circumstances, nothing can be said about Dr. Jones’s test results.

In the area of psychological testing, the source of information about the standards used to administer and score a test can be found in the test’s manual. The testing manual carefully describes the conditions for uniform administration and scoring. This testing manual gives or should give the exact testing materials that must be used, the oral instructions that are given to the person being tested, ways of handling any questions that the person taking the test may have, a description of the minimal requirements for the testing room, and a description of any preliminary demonstrations and/or sample questions to familiarize the person with the testing procedures. The manual also includes all other relevant information about the procedures and details of the testing situation that must be used by the test administrator.

Additionally, a part of every psychologist’s training is learning how not to allow their behavior to influence the results. Accordingly, virtually all psychologists are trained to behave in a manner that will
not allow their personality, rate of speaking, tone of voice, facial expressions, or any other personal variables or factors to enter the testing situation. In fact, the ability to do so is easily taught and learned and it is not unusual, unethical or unreasonable to train and employ a test proctor to administer the psychological tests in a standardized manner. Nevertheless, failure in any of these areas results in a lack of standardization that means that the results obtained from the person taking the test cannot be meaningfully interpreted.

Standardization in scoring a test is every bit as important as standardization in administering the test. Once again, the testing manual for any reasonably useful test provides detailed information on precisely how the test must be scored. How important this is can be seen by imagining the following. Assume Ms. Brown was given a test by Dr. Smith and Dr. Jones. Both Dr. Jones and Dr. Smith administered the test in a standardized manner. However, they scored the test in different ways, resulting in Ms. Brown receiving a score of 12 from Dr. Jones and a 17 from Dr. Smith. Clearly, there is no way of knowing which score, if either, is correct, and therefore nothing can be said about Ms. Brown. Only if we know that one of the doctors used the standardized scoring method could we then say anything about Ms. Brown.

Additionally, a test and the results it generates can only be considered meaningful if there are objective standards for interpreting those results and if the doctor uses those standards. Consider the following. Dr. Smith and Dr. Jones both give the same test to Ms. Brown and use the standardized instructions and scoring methods. In both cases Ms. Brown receives a score of 12. However, Dr. Smith and Dr. Jones take different paths at this point with regard to interpreting their findings. Dr. Smith uses the standardized interpretation based on the extensive research of the test developer to draw conclusions about Ms. Brown’s psychological status. In contrast, Dr. Jones comes up with his own unique interpretation of the meaning of Ms. Brown’s score. Clearly, Dr. Jones’s interpretation is virtually meaningless if not damaging to the conclusions drawn in the report of his evaluation and these conclusions must be considered to be substantially flawed.
II. Normative Testing Data

If I tell you that our hypothetical Ms. Brown scores 100 on The New Jersey Test of Intelligence and give you no other information, I have told you nothing about that person’s abilities, personality, psychopathology or anything else that is meaningful. A score of 100, or any other number, is only meaningful if I know how that score compares with other people. However, if I told you that a random sample of people drawn from all walks of life in the United States took this test and the arithmetic mean or average of that group was a score of 100, then you would know that Ms. Brown received an average score on The New Jersey Test of Intelligence.

If I now tell you that Ms. Brown received a score of 80 on The New Jersey Test of Intelligence, and that the higher the score the higher the level of intelligence, what might you conclude? Well, if you said that Ms. Brown performed at a level that is below the average you would be correct. But, what does that mean? It doesn’t really mean anything until I somehow give you information that further places Ms. Brown’s score in relation to the sample of the entire population. For example, if I now tell you that a score of 80 or less is obtained by only 10% of the population, you would reasonably conclude that Ms. Brown has some intellectual impairment as she is in the lowest 10% of the population. Similarly, if I told you that a score of 80 or less is obtained by 40% of the population you would be much less concerned about Ms. Brown having some intellectual impairment since she is not that far away from being average. In fact, maybe she just was having a bad day and the next time she will be tested she might receive a score of 100 or more.

Test results cannot be meaningfully discussed unless you have data about the scores of the general population. The concept of a “general population” refers to the entire population of, say, the United States. However, a population can be defined in any way. For example, if we wanted a test to be administered just to women between the ages of 18 and 30 who lived in New Jersey, the population would be defined as all women who live in New Jersey and are between the ages of 18 and 30. Population data, regardless of the specific population being measured, is called normative data. When these data are collected on a specific set of individuals defined
as the population, the test is said to be “normed” on that population.
If a test is “normed” on one population, conclusions about people who
do not fall into that category cannot be made. Thus, if you normed a
test on women living in New Jersey who are between the ages of 18
and 30, you could not administer that test to men in Arkansas and
draw any conclusions about those individuals.

Normative data may come in a variety of forms. In one form
there may be two sets of data. For example, let’s imagine there is a
test called the Nebraska Test for Schizophrenia. During the test’s
development it may have been given to a large number of people that
are known not to have Schizophrenia and to a large number of
people that are known to have Schizophrenia. These are two
different populations. Let’s say that people with Schizophrenia get
scores between 100 and 140. Let’s also say that people without
Schizophrenia get scores between 30 and 80. Now if I tell you that
Ms. Brown received a score of 72 you could reasonably conclude that
she does not have Schizophrenia. Clearly, without normative data
that tells you where a person’s score places them in regard to the
normative populations, their score has no meaning whatsoever.

Finally, in discussing norms or normative data it is important to
point out that norms have been collected for various populations. In
short, people from different subcultures may perform differently on
any given test. Unless some information exists on how those
subcultures perform, or it can be reasonably assumed that they do
not perform differently than the population on which the test was
developed, one cannot attach much credibility to a person’s test
performance on that instrument.

III. Test Validity

One of the most important questions that can be asked about a
test is, how valid is this instrument and its results? Another way of
phrasing this question is, does the test really measure what it is
supposed to? Virtually any psychologist or mental health
professional can write a test, for say clinical depression, in about one-
half an hour. The psychologist can, for example, chose to write a 30-
item true-false test and call it The New Jersey Test of Clinical
Depression. They can then state that if the person answers more than half of the items “true” that they are clinically depressed. They can also state that the higher the number of items answered “true,” the worse the depression. But how meaningful is such a test? Does it really measure clinical depression? It does if it can be shown to be a valid measure of clinical depression.

As noted above, validity is the degree to which a test measures what it says it measures. This is usually expressed as a number between –1.00 and +1.00. That number is called a correlation coefficient. Tests with higher positive numbers have more validity. Tests with lower numbers approaching zero do not measure what they are supposed to measure, and for all intents and purposes are useless. Solely for discussion purposes we can say that tests that have high correlation coefficients, say +.80 or higher, are valid instruments, while tests with correlation coefficients in the lower range, say +.07 or lower, are clearly not valid or are virtually useless in measuring what they set out to measure. However, keep in mind that in reality there is no magic number that defines and separates a valid test from one that is not valid. Nevertheless, only if a psychologist uses a test that has a high degree of validity can any confidence be placed in any conclusions relying on that test’s scores.

The validity of a test as found in the correlation coefficient is determined by seeing if that test agrees with an accepted measure of what the test is supposed to measure. For example, in the case of the imaginary New Jersey Test of Clinical Depression one way to establish or measure it’s validity is to give the test to a relatively large number of people who are known or thought to be representative of the population in say the United States. Either before or after, or perhaps a little of both, those same people are interviewed by experienced mental health professionals who then decide if each individual is clinically depressed and if so, how severely. Of course it is important that the interviewer has no prior knowledge of how the person performed on the test. It would be even better if they did not know they were interviewing the person as part of a test validation procedure, lest their own expectations influence the outcome of the interview. Regardless, the test developer, having obtained this independent data from the interviewers, uses correlations to determine the relationship between what the mental health
professionals decide and what the test scores show. If the correlation coefficient shows a strong positive relationship between the test scores and the decisions made by the mental health professionals such that people who receive high scores on the test also are judged to be more severely depressed, and vice versa, then the test is said to be valid for assessing clinical depression.

IV. Reliability

As part of the process of developing tests before they are released for use by practitioners in the field, it is crucial to determine the test’s reliability or consistency. A test is perfectly reliable or consistent if it always comes up with the same score. However, there are no such tests in psychology. If for no other reason than because people are different from one time to another, one can expect that even the best tests in psychology will show some difference in scores at different times. Let’s go back to Ms. Brown. Let’s say that Dr. Smith gives her the New Jersey Test of Clinical Depression on Monday and she scores 12. He then gives her exactly the same test on Friday and she scores 12 again. If we can judge by this one instance, which we really cannot do, we would say the test was perfectly reliable. In fact, in developing tests before they are released, the developer assesses its reliability by such techniques as repeatedly giving the same test to a large number of individuals who are representative of, for instance, the entire population and then noting the test’s consistency. Again, this consistency is measured with a correlation coefficient that varies between –1.00 and +1.00. High positive numbers mean the test is very consistent. Clearly, the more reliable or consistent the test has been shown to be, the greater the confidence that a psychologist can have in drawing conclusions about a person from the test’s score. The best analogy I’ve ever heard involves considering a ruler. If you had a ruler that one day told you that an object you were measuring was 4 inches long, and the next day told you it was 8 inches long, what good would that ruler do you?
V. What to Look For in Psychological Tests

Whether one is reading or writing a report of a psychological evaluation, it is important to come to some conclusion about the nature of the psychological test data that are contained in that report in order to appreciate the conclusions drawn from those data. From the above discussion you can anticipate that if a test is not standardized, not objective, not valid, not reliable or inappropriately administered and/or interpreted, then virtually nothing can be said about the person who was tested. Unfortunately, in my experience this is not an uncommon occurrence in psychological evaluations done for litigation purposes. In fact, I find it embarrassing to my profession to note the relatively large frequency with which psychologists have completely ignored even the most simple standardized instructions by, for example, allowing a person to take a test at home under unsupervised conditions where it is not clear that the person actually took the test or, if so, under what conditions.

Another major source of useless testing information is subjectively interpreted tests. One such set of tests is called Sentence Completion Tests. There are a relatively large number of such tests that can be purchased from various test publishers. At times, various practitioners make up their own instruments. A sentence completion test is a projective test. Unlike objective tests that typically provide individuals with items or questions with a limited number of possible answers, projective tests are unstructured tasks in which the person being tested is given a virtually unlimited number of possible responses. The underlying assumption is that the way the person perceives or interprets the material will give them an opportunity to project such things as their thoughts, feelings, and attitudes into the situation, which will give the test examiner a view into those thoughts, feelings and attitudes. In a sentence completion task the individual is given the first part of a sentence and asked to complete it in any way they deem appropriate. The doctor then “interprets” the results in a manner that they decide is reasonable. Unfortunately, these tests are completely subjectively interpreted, as there are no standards for their interpretation. Clearly, there are also no validity scales, or objective methods for assessing the patient’s test-taking attitudes or credibility. Thus, sentence completion tests by virtue of their subjectivity are not useful in medical-legal evaluations.
Additionally, I would like to note another important flaw that is often found in psychological testing in forensic evaluations. That flaw is the use of tests that may be objective but do not have any validity. Unfortunately, anyone can write a psychological test. In fact, while I was a professor and teaching testing to students in clinical psychology classes, as an exercise for the students to perform, I would pick a concept such as “interpersonal warmth,” divide the students into groups of 3 and 4 and ask them to write a 20-item test to measure the presence of that concept. Invariably this was a task easily done in about one-half an hour. In fact, almost anyone can do so with little or no professional training. Moreover, as near as I can tell, there is no barrier for anyone who wishes to write, publish and market such a test. Of course, the major issue concerns the test’s validity. The reason I bring this up is that in my experience there are a lot of tests being used that are hardly better than what my students could generate in that one-half an hour.

The only saving grace to the sorry state of publishing and selling tests without validity or reliability is the psychological testing literature. That psychological literature is the gold standard for determining the ability of a test to do what it is supposed to do, i.e., reliably and validly measure some aspect of a person’s behavior, feelings, thoughts, personality and/or psychopathology. Psychological testing has now been around for over 100 years. The major source of credible information on psychological tests is the published psychological literature. In this regard, the American Psychological Association maintains a database, called PsycINFO, which contains references to nearly 2.4 million articles from over 2,200 journals published in 27 languages between 1887 and 2008. Ninety-eight percent of the articles in the database have been through an extensive process of editing and reviewing called refereeing that virtually guarantees the credibility of their contents. The articles in the database contain the results of research on a vast number of psychological tests. Before using any test or commenting on its properties it is a good idea to check that literature to determine if the test has been the subject matter of any research that indicates its validity, reliability and applicability to various populations. As a basic rule, if the test has not been shown by published research in refereed or edited scientific journals to be a valid and reliable measure of what it purports to measure and is applicable to known
populations, then it cannot provide any meaningful information about anyone.

Additional information about specific psychological tests can be obtained from the *Mental Measurements Yearbook* and *Tests in Print*. The *Mental Measurements Yearbook* provides factual information on all known tests published in the English-speaking countries of the world as well as test reviews written by professionals in the field. The yearbook has been published at various times since the 1930's. Each yearbook provides information about newly reviewed tests rather than including data on previously discussed instruments. Since 1935 the Buros Institute has provided professional reviews of over 11,000 tests. The current edition is the *Seventeenth Mental Measurements Yearbook* (Geisinger, Spies, Carlson, & Plake, 2007). Not all of the tests appearing in the *Mental Measurements Yearbook* are available commercially, although there are almost 4,000 commercially available tests of which about 2,500 have been reviewed by Buros. Additionally, a companion publication, *Tests in Print*, provides a list of all known currently available commercial tests with information about where to obtain critical test reviews (Murphy, Spies, & Plake, 2006).

In short, psychological tests are not capable of providing meaningful information about people undergoing psychological evaluations in conjunction with litigation unless they are objectively administered, scored and interpreted; standardized so that everyone employing the tests uses exactly the same procedures for administering, scoring and interpreting the results; administered, scored and interpreted in the objective and standardized manner in which they have been specified for use in the testing manual; and have been found to be valid and reliable as determined by the vast body of psychological testing literature found in edited or refereed professional journals. Given the open accessibility to the existing wealth of information on psychological tests there is virtually no excuse for using worthless instruments.
VI. The Doctor’s First Responsibility: Measuring Credibility

Finally, and most importantly, it should be noted that it is absolutely imperative that the examining physician obtain objective psychological test data in order to formulate a diagnosis, a prognosis and, if necessary, a treatment plan. When there are no psychological test data the doctor’s evaluation is most assuredly substantially flawed since there are absolutely no objective data that can be reviewed by an independent and impartial observer in the context of a courtroom. Moreover, the first responsibility of any medical-legal examiner in psychology or psychiatry is to determine the credibility of the individual’s complaints and presentation and the principal method for assessing this credibility is the objective psychological test battery. While tests with scales to assess the person’s test-taking attitudes and credibility are relatively few in number, they do exist, and are needed to establish that the person being evaluated is not exaggerating or attempting to simulate symptoms in order to obtain unwarranted benefits from their litigation. Once that credibility has been established, the test battery can then provide objective psychological data concerning any psychopathology that might exist. Unfortunately, it happens all too frequently that there are no objective psychological test data, but only the doctor’s subjective opinions.

VII. Validity Scales and Test Validity: Examinee Honesty and Attorney Coaching

To review what was discussed above, “test validity” refers to whether or not a test measures what it says it measures. The validity of a test is usually expressed as a number between −1.00 and +1.00. That number is called a correlation coefficient. Tests with higher positive numbers have more validity and therefore when they are administered one can have more confidence in concluding that they measure what they are supposed to measure. Tests with lower numbers do not measure what they are supposed to measure and for all intents and purposes are useless.

One common error that individuals who are not familiar with psychological evaluations frequently make is to confuse the concept of “test validity” with “validity scales.” In contrast to test validity,
validity scales are scores generated by the person’s responses to the test items that provide information about whether they were attempting to “fake bad,” feign symptoms or complaints, or trying to simulate symptoms. Most importantly, validity scales can also provide information about whether the patient is “faking good,” or trying to appear to be more emotionally well composed than they actually are, or attempting to deny symptoms of a real disorder. Additionally, validity scales are capable of providing the test administrator with scores that allow them to determine if the individual read the test items carefully, or at all. With minimal exceptions, validity scale data are typically the only form of psychological data generated by a report that speak directly to the person’s credibility and provide objective data that is open to public inspection and can be presented to the court.

Relatively few tests have validity scales and it is up to the psychologist conducting the examination to make sure that they administer a test that contains validity scales. This is especially important since there have been multiple reports in the professional journals indicating that not only are claimants in litigation open to distorting their true psychological conditions but that the attorneys representing them have been known to coach their clients on how to take psychological tests in an attempt to appear to have dysfunctions that do not exist (e.g., Lees-Haley, 1997; Youngjohn, 1995).

Although relatively few tests have validity scales, the process for developing them is straightforward and there does not appear to be any easily understood reason why most non-projective instruments such as inventories and questionnaires do not have validity scales. Quite simply, in order to develop a set of validity scales all one has to do is to give the test to four different groups of people who are asked to take the test under different sets of instructions. One group is told to “fake bad,” another is told to “fake good,” a third is told to answer the questions without reading them, and the fourth is told to answer honestly. One could add another group, in the case of developing a test, for, say, clinical depression, by obtaining a group of people who are known to be depressed and asking them to take the test in an honest and frank manner. By simply noting which items are responded to in a different manner by the four or five groups, it is possible to develop a set of questions or a
scale that distinguishes between people who are faking good, faking bad, not reading the questions, answering honestly but are not necessarily depressed and those who are actually depressed. Why this is not done routinely as part of the test development process is not clear. Most probably, the answer is that most tests are constructed for assessing people who are expected to behave in an honest manner, and not for people who are motivated to appear different than they actually are. However, for forensic purposes one should never use a test battery that does not contain a test that can be reasonably expected to measure patient credibility.

VIII. What Can Psychological Tests Measure?

The list of things that psychological tests can measure is quite long. Among other things, psychological tests can measure aptitudes, intelligence, interests, values, attitudes, personality, psychopathology, memory, learning ability, attention, and achievement. Psychological tests are employed in a variety of contexts. For example, they are used in schools as a counseling aid, on the job to predict performance, in clinics and private offices to assist with the diagnosis of mental disorders, as screening devices for hiring and promotion, to assist neurologists and other medical practitioners, and to predict consumer behavior. While there are currently thousands of commercially available tests, as we have seen, whether any given instrument is valuable or not depends on the factors I have discussed above. In my practice I am interested in using tests that will help me determine if the person has or has had any psychopathology or a psychological disorder. In the next chapter I will discuss at length and critically evaluate the many tests I have encountered in my practice.
Chapter 7

The Most Frequently Used Psychological Tests in Litigation

Over the last 23 years I have participated in the evaluations of thousands of patients. Most frequently, other psychologists or psychiatrists have evaluated these individuals either before and/or after my examination. In a very large percentage of these cases I have reviewed those other doctors’ reports and commented on their psychological testing in my own reports. As part of the process of running my practice I have kept a careful record of all of the psychological tests I have encountered. In this section I will describe all of those tests and what I have discovered about them.

For many of the tests I discuss it is readily apparent that, by the standards discussed above, these tests are virtually useless in providing credible information about the test-taker’s psychological status. In other cases the tests I have described have been shown by published research to be valuable tools in understanding an individual’s psychological status. In yet other cases the value of a particular test is not entirely clear. In these cases I have attempted to discuss the usefulness and limitations of these tests based on the research data in the psychological literature. Where applicable I have tried to present both sides of the argument.

One thing that must always be kept in mind is that the mere publication and marketing of a test, and the claim that it measures something important, is not in any way sufficient to warrant its use in assessing psychopathology and credibility. A test only warrants that use if it has undergone the scrutiny of published research in refereed journals that demonstrate that the instrument has been shown to be effective in measuring what it purports to measure. My overall impression, and the message I will be conveying in this section, is that there are a large number of tests being used in psychological evaluations conducted in conjunction with litigation that simply are not capable of providing meaningful information. Similarly, there are relatively few instruments that have been shown by research to be useful. Of course, it is important to be able to distinguish between useful and useless tests.
Finally, the tests that I have described below are not intended to be a cross section or compendium of all the available instruments or in any way representative of any subset of tests other than what I have encountered in my practice. Nevertheless, the tests I have discussed have been shown to include the most frequently used instruments in psychology.

I. The Different Types of Tests

Tests can be placed into two different categories according to the methods they employ and the type of information that they seek. When it comes to methods there are, projective tests, rating scale tests, questionnaires, and performance tests.

Projective tests all share a single common feature. They present the person being tested with an ambiguous or unstructured stimulus or task such as an inkblot, a photograph of people engaged in an uncertain task, or the beginning of a sentence that is to be completed. The basic notion is that the people taking the test will reveal something about themselves by the manner in which they project their motivations, emotions, and needs into completing the task. In interpreting the results the psychologist typically uses their experience to subjectively interpret the meaning that is supposedly revealed by the test-taker’s projections or productions. With minimal exceptions there are no accepted standards based on reasonable research for interpreting projective test data. In fact, one criticism of all projective tests is that they may be more revealing about the psychologist than the test-taker! This criticism simply questions whether the psychologist, in the absence of objective standards for interpreting the person’s projections, is simply projecting their own motivations, emotions and needs into what the person has said.

Rating scale tests typically present the person being tested with a statement asking him or her to quantify their feelings, thoughts, behaviors, interests, values and attitudes that relate to that statement with a choice that is said to measure those attributes. For example, a typical statement might be, “I have a good appetite.” The test-taker is then asked to rate this statement as to how true it is of their behavior. The number of choices typically varies from three to seven. For
example, in a three-choice situation the choices might be, (1) All the
time, (2) Some of the time, (3) Never. One underlying assumption in
rating scales is that the numbers associated with the answers, for
example 1, 2 or 3, imply more or less of the feeling, thought or
behavior being measured.

Questionnaires are, as the name implies, composed of a series
of questions. They may be “true-false” or offer multiple choices. For
example, in the very famous Minnesota Multiphasic Personality
Inventory (MMPI) an example of a question that could be, but is not
on the test is, “I am often very nervous.” By using a large number of
questions that are designed to measure, say, “nervousness,” or any
other factor, in slightly different ways the test can determine how
much “nervousness” is present by how many questions are answered
in the same way. Tests like the MMPI often use questions that do not
seem to have any direct connection with what is being measured.
However, if the test is constructed and researched carefully, those
seemingly indirect questions are known to be directly related to what
the test is supposed to measure, such as a personality trait or some
form of psychopathology.

Performance tests measure some tangible sample of behavior
in the testing session. For example, if one is interested in an
individual’s arithmetic ability the person would be given a test with a
relatively large number of arithmetic problems that would typically
vary in difficulty. The number of correct answers would then be the
simplest measure of arithmetic ability. Intelligence tests and tests of
memory fall into this category. In the case of intelligence tests the
individual might be asked to answer questions dealing with arithmetic
manipulations, verbal abilities, proverbs, similarities or differences
between groups of items, etc. In tests of memory they might be
asked to read something and then asked to recall that information at
a later time.

Often the type of information sought is associated with a
particular method, such as the tests of memory just discussed.
However, sometimes this is not true and diverse methods can be
used to provide information about different issues. For example,
there are tests of psychopathology that try to determine if an
individual has a specific disorder, say Schizophrenia, or some type of
sign and/or symptom of a disorder such as depression or anxiety. There are other tests that try to determine the presence or quantity of a personality factor or factors such as assertiveness, independence, warmth, etc. Sometimes these tests try to determine a person’s needs such as the need for affiliation with others, the need for solitude, the need for socialization etc. Finally, as alluded to above, there are tests that attempt to determine a person’s level of skill either in a general area, such as intelligence, or in a specific area such as memory.

Overall, as discussed earlier, tests that are objective, reliable, and valid, and that can assess truthfulness are the most useful in forensic psychology. Unfortunately, all too often there are tests that are employed in medical-legal evaluations that fall short of these criteria in one or more ways. Nevertheless, when evaluating a psychological test battery used in a forensic examination one must always keep in mind the question being asked by the test and how well the instrument selected to answer that question is capable of providing meaningful data.

**Arizona Sexual Experiences Scale (ASEX)**

The Arizona Sexual Experiences Scale (ASEX) is a self-report instrument that was designed to provide information about sexual functioning and satisfaction. The test requires the individual to rate five items concerning their sexuality on a six point rating scale. The dimensions rated are sexual drive, arousal, vaginal lubrication or penile erection, the ability to reach orgasm, and satisfaction derived from orgasm. With five items and a six-point scale the possible total scores range from 5 to 30, with the higher scores indicating more sexual dysfunction. A search of the PsycINFO database maintained by the American Psychological Association, indicates that there have been exactly 14 published studies utilizing this rating scale. An examination of the original article describing the instrument, as well as the additional studies in the literature, reveal insufficient data to indicate that this rating scale can be used to assess sexual functioning in a medical-legal context. The principal problem with the scale is that it was not developed on a diverse sample that can be
considered representative of the general population but on a relatively few hospital and university employees and psychiatric patients. Furthermore, the instrument itself provides no method for assessing an individual’s attempts to simulate dysfunction (McGahuey, Gelenberg, Laukes, Moreno, Delgado, McKnight, & Manber, 2000).

Babcock Story Recall Test

The Babcock Story Recall Test is a neuropsychological instrument used to assess memory. In this test the individual is read a short story in the form of a single paragraph that contains 21 items or units. After listening to the story or paragraph the individual is asked to recall as much of the story as they can. After approximately 20 minutes the individual is again asked to recall the items in the story. Individuals with different levels of organic or neurological impairment show different levels of performance. An inspection of the psychological literature reveals that while for the last 70 years the test has been used to assess memory in individuals with neurological disorders such as epilepsy and dementia, it is not known to be a valid or reliable measure of psychopathology in cases where there may have been non-neurological injuries.

Beck Anxiety Inventory

The Beck Anxiety Inventory is a self-report rating scale on which the individual is asked to use a 4-point rating scale, ranging from 0 to 3, to describe him or herself on 21 items that are assumed to be common signs and/or symptoms of anxiety. Some of the items are, “Fear of worst happening,” “Feeling of choking,” “Dizzy or lightheaded,” “Unable to relax.” The individual’s scores can vary from 0 to 63, with higher scores reportedly being related to high levels of anxiety. Unfortunately, there are no validity scales for this test that would allow the doctor to determine the credibility of the individual’s responses. Without such scales to assess attempts at simulating symptoms, this instrument is not capable of generating any demonstrably meaningful information about an individual’s psychological status at any point in time.
**Beck Depression Inventory**

There are three versions of the Beck Depression Inventory called the Beck Depression Inventory (BDI), the Beck Depression Inventory-1A and the Beck Depression Inventory-II (BDI-II). They were published in 1961, 1971 and 1996 respectively. All three versions are self-report questionnaires in which the person is asked to rate him or herself on how they have been recently feeling. The 21 items on the most recently revised edition requires ratings on a four point scale ranging from 0 to 3 on such generally accepted signs and/or symptoms of clinical depression such as hopelessness, irritability, guilt, fatigue, weight loss and a loss of interest in sexual relations. The individual’s total score on the 21 questions is used to draw some inferences about their psychological status, with high scores said to reflect greater amounts of depression. With regard to its use in medical-legal examinations the Beck Depression Inventory has been criticized on two major fronts. First, it is susceptible to symptom simulation and/or exaggeration since it has no validity scales for assessing the individual’s test-taking attitudes or credibility. Second, many of the questions on the Beck Depression Inventory concern physical signs and/or symptoms that the individual may have as a result of being physically ill or injured rather than depressed. These limitations mean that the Beck Depression Inventory is not capable of generating any data that can provide any demonstrably meaningful information about an individual’s psychological status in a medical-legal context, especially if that person has some physical disorders.

**Beck Hopelessness Scale**

The Beck Hopelessness Scale is a self-report instrument that contains 20 true-false items designed to measure hopelessness, which is defined as negative attitudes about the future and a loss of motivation and realistic expectations. Each of the pessimistic choices is given a score of 1 so that the total scores varies from 0 to 20, with 20 reflecting a high level of hopelessness. In a review of the literature, it was found that the Beck Hopelessness Scale is effective in identifying individuals who are at high risk for suicide and non-fatal self-harm (McMillan, Gilbody, Beresford, & Neilly, 2007).
Unfortunately, the Beck Hopelessness Scale, as is true of the other Beck scales, has no validity scales for assessing the individual’s test-taking attitudes, credibility, or attempts at simulating dysfunction and therefore is not capable of generating any meaningful information about an individual’s psychological status in a medical-legal context.

**Beck Scale for Suicide Ideation**

The Beck Scale for Suicide Ideation is a 21-item self-report test that surveys attitudes, behaviors and plans that the individual may have had to commit suicide in the previous week. The first 5 items measure the wish to live and die, the reasons to live and die and active and passive suicidal ideations. An example of an active suicidal ideation is having a strong desire to kill oneself. An example of a passive suicidal ideation is not taking precautions to avoid death in a life-threatening situation. If, as determined by the first 5 items, the test-taker has had no active or passive suicidal ideations they are directed to the last two questions on the test, which assess the number of previous suicide attempts and the seriousness of the intent to die that occurred with the last attempt. If the test-taker has had some active or passive suicidal ideations they complete items 6 through 19. The first 19 items are scored on a 3-point scale with scores ranging from 0 to 2. Zero is defined as, “I have a moderate to strong wish to live,” 1 is defined as, “I have a weak wish to live” and 2 is defined as, “I have no wish to live.” Thus, the individual can receive a score ranging from 0 to 38. Severity is denoted by the size of the score although it is suggested that the clinician carefully investigate any evidence of suicidal ideation in an interview. With regard to the applicability of this test to medical-legal examinations, there clearly are no validity scales for assessing individuals who are intent on feigning suicidal ideations, although any such assertions must be clearly investigated for credibility.

**Bender-Gestalt Test**

The Bender-Gestalt Test is used as an initial screening device to diagnose organic brain impairment and impairments in perceptual and motor functioning. The test requires that the person copy nine
simple line drawings with a pencil. The person is shown the drawings one at a time and asked to make as accurate a copy as possible. A scoring method devised by Dr. Patricia Lacks provides an objective measure for interpreting the results (Lacks, 1984). The Bender-Gestalt Test can be useful in determining if a clinical depression may be the result of an organic brain impairment and may suggest when it is wise to have a comprehensive neurological and/or neuropsychological examination. Unfortunately, on occasions psychologists have been known to make extensive interpretations concerning an individual’s personality characteristics and/or symptoms of a psychological disorder from the test-taker’s reproductions of the Bender drawings. However, judging by the absence of psychological literature supporting this procedure, these interpretations are not credible.

California Psychological Inventory (CPI)

The California Psychological Inventory (CPI) is a self-report inventory in which the person is asked to respond “true” or “false” to each of 480 declarative statements. 178 of the questions were taken from the Minnesota Multiphasic Personality Inventory (MMPI). Items that are similar to those found on the CPI but that are not on the test are, “I enjoy reading mystery novels” and “Most people are easy to understand.” The CPI questions are grouped into 18 scales. Fifteen of the scales are designed to measure what are conceived of as personality dimensions such as Dominance, Sociability, Self-Acceptance, Flexibility and Tolerance. The three remaining scales are validity scales. Two are intended to measure the individual’s attempt to either “fake bad” or “fake good,” that is to try to create overly positive or overly negative impressions of him or herself. The third validity scale is designed to detect individuals who have not approached the test in a conscientious way by carefully reading and answering the questions or who have responded to the items in a random fashion. One of the major advantages of the CPI is that the items were selected based on their ability to predict performance on the various scales rather than by the content of the questions. Thus, there are items that do not seem to be connected to any particular personality dimension, leading to the conclusion that the test items are not transparent as to their intent. Once having scored each of the
test’s scales, the scores on the fifteen personality scales are not interpreted individually. What the test administrator does is interpret the profile or pattern of scores. Unfortunately, the testing manual for the CPI indicates that this method of interpretation is “an art depending upon general psychological sophistication and practical experience with the testing instrument” in addition to technical and research knowledge of the test (Gough, 1975). As such, it is readily apparent that the CPI is subjectively interpreted, a reason for its lack of general usefulness in a medical-legal context. Another reason for not using the CPI in a medical-legal examination is that it was designed for use in assessing normal individuals rather than those who are psychologically disturbed, and is therefore not known to be capable of assessing psychopathology.

**Cattell Sixteen Personality Factor Test (16PF)**

The Cattell Sixteen Personality Factor Test (16PF) is a questionnaire that provides a measure of the patient on what have been shown by over 50 years of research to be 16 independent dimensions of personality. This same research has demonstrated that the 16PF can also provide information about any psychopathology that might be present. Very simply, the test requires the person to answer 187 questions with one of three possible answers. The choice of answers varies depending on the question. One such type of question that is not actually part of the test is in the form of a statement that reads, “I prefer having friends who are: (a) quiet, (b) in between, (c) lively.” Once having answered the questions there are well known, valid and reliable objective methods of scoring. These methods provide specific information about the person’s personality and psychopathology and yield numerical scores indicating if the individual has attempted to portray him or herself in an unrealistically favorable or unfavorable light. In short, this methodology determines if the test-taker is “faking-good” or “faking-bad,” or, alternately, if they have answered the test in an honest and frank manner or adopted an unspecified deviant test-taking strategy. In cases where they have not been honest and/or have demonstrated a deviant test-taking strategy, nothing further can be said about the person’s psychological status. Overall, there has been a substantial amount of research in refereed professional
journals and books indicating that the 16PF provides objective, quantifiable, valid and reliable information about personality traits and psychopathology (e.g., Cattell, 1989; Karson, & O'Dell, 1976). As such, the 16PF is very useful in providing objective, valid and reliable information in medical-legal cases.

Clinical Analysis Questionnaire (CAQ)

The Clinical Analysis Questionnaire (CAQ) is very much like the Cattell Sixteen Personality Factor Test (16PF). In fact, they both were developed and published by the same group, the Institute for Personality and Ability Testing, and share many of the same questions or items. Like the 16PF the CAQ is a multiple choice test in which the test-taker is asked to select one of three alternatives that best describe their feelings about 272 declaratory statements. Additionally, like the 16PF the CAQ provides information about an individual’s sixteen basic dimensions of personality. Moreover, the test provides explicit information on 12 dimensions of psychopathology with specific scores quantifying dimensions such as hypochondriasis, agitation, guilt and resentment, paranoia and psychological inadequacy. An inspection of the testing manual reveals that there is a method for determining the individual’s test-taking attitudes or credibility by scoring what is called the V Scale or the validity scale. This scale is composed of 10 questions that when scored is somewhat modestly capable of providing information about whether or not an individual has completed the test in an honest and frank manner. However, in addressing this issue the authors of the test offer the following suggestion, “The best way to control conscious tendencies to distort is to help the examinees see that accuracy is to his or her advantage as well as that of the examiner” (Krug, Cattell, & IPAT Staff, 1980). While this may be useful advice in a general clinical setting, this comment simply points out what appears to be a lack of confidence in the use of their validity scale which in turn raises questions about the usefulness of the CAQ in a medical-legal examination where it is not reasonable to assume that the individual is taking the test in a straightforward manner or that they can be convinced to do so. As such, any data collected with the CAQ is subject to the criticism that it cannot be assumed to provide a valid portrayal of the person’s psychiatric status.
Comrey Personality Scales (CPS)

The Comrey Personality Scales (CPS) is a test that was designed to determine the amount of each of eight basic personality dimensions or traits that the author of the test discovered through factor analytic studies. These dimensions are trust vs. defensiveness, orderliness vs. lack of compulsion, social conformity vs. rebelliousness, activity vs. lack of energy, emotional stability vs. neuroticism, extraversion vs. introversion, masculinity vs. femininity and empathy vs. egocentrism. There are 180 simple items on the test. Examples of similar items that are not actually part of the test read as follows, “It would be hard for me have a lot of fun” and “I like having friends who are fun.” In the former, the person answers by picking one of seven alternatives that corresponds to their estimate of how true the statement is of them. In the latter, the person answers by picking one of seven alternatives that corresponds to their estimate of how rarely or often the statement applies to them. The items are objectively scored and the individual is reported as having more or less of the eight different personality dimensions. Judging by statements made in the testing manual the author of the test does not have any confidence that either scale can objectively determine if the person is responding to the items in an honest manner (Comrey, 1970). Accordingly, in a medical-legal context this test is of little use in assessing an individual’s psychological status.

Coping Responses Inventory – Adult Form

The Coping Responses Inventory-Adult Form is a 48-item test designed to determine the strategy used by the person in coping with a stressor. An example of a question that is not actually part of the test reads as follows, “Did you make a list of all the things you could do to solve your problem?” The person taking the test then makes one of four choices: (1) No, Not at all, (2) Yes, Once or twice, (3) Yes, Sometimes, and, (4) Yes, Fairly often. The items are scored in a manner to characterize the person’s style of coping on what are identified as eight different styles of coping with stressful situations such as “Logical Analysis,” “Seeking Alternative Rewards” and “Seeking Guidance and Support.” The test produces scores that are said to indicate the relative frequencies with which the individual uses
the different coping strategies. Unfortunately, the test does not produce any information concerning either the existence of psychopathology or the truthfulness of the person taking the test (Moos, 1993). Thus, if one can assume that the questionnaire was completed in a frank and honest manner, while it may provide interesting information that could conceivably be used for counseling, it does not appear to provide useful information about psychopathology in a litigation situation.

**Cornell Medical Index (C.M.I.)**

The Cornell Medical Index is a 195-item questionnaire that asks the person to respond “Yes” or “No” to a variety of questions inquiring about a patient’s medical history in 18 different areas including the cardiovascular system, the skin, the eyes and ears, the frequency of illness and psychological signs and/or symptoms. Fifty-seven of the questions are in the area of psychology. The C.M.I. was designed to provide data similar to what is recorded in a comprehensive hospital medical history. The authors of this questionnaire stated that they designed it so that the “physician is not burdened with the task of asking the 195 questions” (Brodman, Erdmann, Lorge, Wolff, & Broadbent, 1949). They also have stated that they believe that “it is possible to review it (the C.M.I.) in as little as one minute.” A reading of the 195 items indicates that while the questions do ask information relevant to an understanding of the individual’s psychological status that the C.M.I. does not have any method for assessing the task taker’s credibility. As such, the C.M.I. is not appropriate for use in medical-legal examinations where, in fact, the presentation of the questions can be an inducement to claim symptoms that do not exist.

**Cowboy Story Test**

The Cowboy Story Test is a test of memory that was first published in 1912 by Dr. Shepherd Ivory Franz (Franz, 1912). The test is administered by reading to, or allowing the person to read, a paragraph describing the behavior of a “cowboy” who went to San Francisco with his dog and bought some new clothes. After a period of time, which can be varied by the test administrator, the person
taking the test is asked to recall what they heard or read. The test is objectively scored and there are normative data that allows for determining the nature of individual’s performance. Neurologists and neuropsychologists frequently use this test as part of their Mental Status Examination procedures designed to measure memory. However, there is nothing in the psychological testing literature to indicate that this test is capable of either assessing psychopathology or of providing information about an individual’s test-taking attitudes or credibility. Clearly, apart from any deficits in memory that may be revealed that could conceivably be related to a mental disorder, such as a Major Depressive Disorder, in a medical-legal context this instrument cannot be used to determine if an individual has a psychological disorder.

**Credibility Scale**

With regard to the Credibility Scale, a review of the PsycINFO database system maintained by the American Psychological Association reveals a single published reference on the Credibility Scale (Lees-Haley, 1990). An inspection of this journal article reveals an attempt to obtain normative data on a 100-item true/false scale intended to be used to identify malingering in personal injury litigants. After describing the data obtained on a sample of psychiatric patients, medical outpatients, college students and volunteers, the author concluded that the results showed a need for broader normative data. That is, his study did not demonstrate that the attempt to develop a scale to detect malingering was successful. No follow-up studies were found in the subsequent 18 years of the psychological literature and there is absolutely nothing in that literature that indicates that the Credibility Scale has any validity or reliability whatsoever with regard to detecting the presence or absence of malingering.

**Davidson Trauma Scale**

The Davidson Trauma Scale is a 17-item self-report scale that is said to measure the frequency and severity of the 17 signs and/or symptoms of a DSM-IV-TR Posttraumatic Stress Disorder as specified in Criteria B, C and D of that disorder. For each sign and/or
symptom the individuals rate themselves on how frequently the sign
and/or symptom has occurred in the last week, with 0 defined as “not
at all” and 4 defined as “every day.” Similarly, they rate themselves
on the severity with which the sign and/or symptom has occurred in
the last week, from 0 defined as “not at all distressing” to 4 defined as
“extremely distressing.” Thus, an individual can receive a score from
0 to 136, 0 to 68 for severity and 0 to 68 for frequency. There is no
reason to suspect that the results of this test are any more credible
than the answers that would be given to an interviewer asking the
same questions about the 17 signs and/or symptoms. Moreover, the
test distributor is very clear in stating that there are no measures in
the test that can assess the truthfulness of the person’s responses.

Digit Symbol Modalities Test – See also Symbol Digit Modalities
Test

Historically, the Digit Symbol Test is not actually considered a
test in and of itself, but one of the 14 scales or subtests on the
Wechsler Adult Intelligence Scale-III (WAIS-III). The Digit Symbol
Test is a brief and easy to administer subtest. In this substitution
subtest, the person is shown a set of nine symbols in the form of
simple line drawings, for example, two short parallel lines extending
from the upper right to the lower left corner of a small square. Each
symbol is associated with a number from one to nine. The person is
then shown 100 boxes with one of the numbers from one to nine
above the box and asked to fill in the box with the associated symbol.
They are given 90 seconds to complete as many of the boxes as
possible. There is evidence in the literature indicating that the test is
essentially a neuropsychological measure of psychomotor
performance and relatively unaffected by an individual’s memory and
learning (Erber, Botwinick, & Storanrt, 1981). There are also data
indicating that it should not be given to individuals who are unskilled
manual laborers, have not completed high school or who graduated
more than 15 years prior to the examination (Lezak, 1983). While the
test is sensitive to brain damage, there is nothing in the literature
indicating that this instrument is capable of providing information
about psychopathology in a forensic examination. Nevertheless, it
appears to be a favorite of psychologists who place it in their test
battery quite possibly because of its simplicity, ease and speed of administration.

**Edwards Personal Preference Schedule (EPPS)**

The Edwards Personal Preference Schedule (EPPS) was based on the work of Dr. Henry Murray, a psychologist who developed the notion of people having a specific set of core psychological needs. According to Dr. Murray, people have 15 basic needs, including those of achievement, order, autonomy, affiliation, dominance, nurturance, change, aggression and consistency. The EPPS is designed to measure these needs. The EPPS is composed of 210 items. Each item consists of a pair of statements that describe two different needs. The person is instructed to pick the statement that best describes their needs. Based on the multiple choices the individual makes, statements can be arrived at that indicate the person’s most and least important needs. Scores can also be obtained indicating the relative importance of all of the needs. There are two validity scales that can measure if the person is reading the questions before answering and can determine if the individual is responding consistently. While this test is useful in assessing a person’s needs and providing insight into their personality, it is not known to be related to psychopathology. Thus, it is of little utility in a medical-legal context.

**Folstein Mini-Mental Status Exam**

The Folstein Mini Mental Status Examination is a shortened version of a regular Mental Status Examination that is not normally considered to be a psychological test, although it frequently appears in psychological testing sections of medical-legal reports. In fact, 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, Folstein, & McHugh, 1975). 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 a brief version of a Mental Status Examination, without the depth or breadth of a normal Mental Status Examination, that was devised to obtain a quick understanding of the mental functioning of psychiatrically hospitalized patients, the use of this “instrument” in medical-legal evaluations is extraordinarily limited.

**Forer Structured Sentence Completion Test**

The Forer Structured Sentence Completion Test is a projective instrument in which the individual is given the first portion of a sentence, called a stem, and asked to complete the sentence in any manner they deem appropriate. There are 100 such sentence stems on the test with approximately equal amounts written in the third-person and the first-person. Clearly, the Forer is subjectively interpreted and has no method for detecting deceptive responding. The testing manual is also very clear in stating on page 6 that there are no normative data for evaluating the individual’s responses (Forer, 1993). As such, this instrument has no validity or reliability with regard to assessing psychopathology in a medical-legal setting.

**Forer Vocational Survey Test (FVS)**

The Forer Vocational Survey Test (FVS) is another sentence completion projective test. This instrument contains 80 items that are intended to investigate non-intellectual processes related to job functioning. Specifically, the individual taking the test is asked to complete sentence stems aimed at identifying the person’s self-perceptions in regard to various work issues such as their relationships with authority, their sense of responsibility, and their belief in their ability. As with other sentence completion tests the items are interpreted subjectively. Additionally, a survey of the PsycINFO database maintained by the American Psychological Association reveals no published information on this test. Accordingly, this instrument has no known validity or reliability with regard to assessing psychopathology and therefore it is not useful in a medical-legal psychological evaluation.
**Graham-Kendall Memory for Designs Test**

The Graham-Kendall Memory for Designs Test has on occasion been simply referred to as the "Memory for Designs Test." It is a neuropsychological instrument that consists of 15 geometric designs that vary in complexity. They are shown to the individual, one at a time, for five seconds each. Immediately after seeing each design the person draws what they have seen. Reproductions are scored for errors in the designs. The test is intended as a measure of brain damage although when compared to tests such as the Bender-Gestalt it has been shown to be substantially less accurate (Heaton, Baade, & Johnson, 1978). Overall, the Graham-Kendall Memory for Designs Test has not been shown to be a valid and reliable test that is useful in assessing psychopathology and is therefore not generally useful in determining if an individual has suffered a DSM-IV-TR psychological disorder if so claimed in their litigation.

**Guilford-Zimmerman Temperament Survey (GZTS)**

The Guilford-Zimmerman Temperament Survey (GZTS) is a questionnaire that is designed to provide information about an individual’s personality characteristics. It was intended as a tool for use in career planning as well as counseling and research. It was not intended to provide information on psychopathology. As with many other personality characteristic tests the GZTS grew out of factor analytic studies intended to identify the minimum number of factors that would account for all the personality differences among individuals. Four of the 10 variables or traits measured are: sociability, emotional stability, friendliness and thoughtfulness. The test itself is composed of declarative statements about the test-taker and other people that are answered either “Yes” or “No.” Examples that are not actually part of the test read as follows, “I am often in good spirits” and “Most people are trustworthy.” As with many of the personality survey instruments I have discussed, the GZTS is not appropriate for use in a medical-legal examination as there is no method for establishing truthfulness of the individual’s responses nor was the test designed or later demonstrated to provide information about psychopathology, even in a non-forensic context.
**Hamilton Anxiety Scale**

The Hamilton Anxiety Scale (HAS) is frequently cited in psychological testing sections of psychological reports. However, the HAS is not a psychological test since it does not administer any physical material to the person being “tested” (Hamilton, 1959). The HAS is simply a list of what was accepted in 1959 as fourteen frequently accepted symptoms or complaints of anxiety. Instead of presenting the patient with any material to respond to, as is done with a psychological test, the doctor examining the patient simply rates the patient on a five-point scale according to how extensively the doctor believes the patient is experiencing each of the thirteen symptoms. As such, the HAS does not obtain any objective measures of the patient but is simply an alternate way of the doctor subjectively stating their opinion that the patient has anxiety. In a medical-legal context, the HAS has no known objective relationship to the existence of any DSM-IV-TR psychological disorders.

**Hamilton Depression Scale**

Like the Hamilton Anxiety Scale, the Hamilton Scale for Depression (HSD) is not a psychological test in the sense that it presents any physical material that is administered to a patient (Hamilton, 1960). The HSD is simply a list of what, in 1960, was believed to be 21 frequently accepted symptoms or complaints of depression. Instead of presenting the patient with any material to respond to, the doctor examining the individual simply rates them on either a three- or a five-point scale according to the extent the doctor believes the person is experiencing each of the symptoms. As such, the HSD is not capable of obtaining any objective measures of the patient, but is simply an alternate way of the doctor stating their subjective opinion that the patient is depressed. Additionally, the HSD has not been the subject of any significant amount of research. Moreover, the author of the HSD expressly intended for it to be used with patients that already were diagnosed as having a Depressive Disorder. As such, it was not intended to be, and has no known utility, as a diagnostic tool. Clearly, in a medical-legal context it has
no known relationship to the existence of any DSM-IV-TR psychological disorder.

**Hilson Life Adjustment Profile (HLAP)**

The Hilson Life Adjustment Profile (HLAP) is an instrument that is used in the pre-employment screening of public safety personnel. The aim of the HLAP is to collect information about an individual that can assist a personnel officer in making a decision about a job applicant’s ability to function in a high-risk occupation such as a police officer. Unfortunately, the HLAP has no known validity or reliability with regard to determining psychopathology either in the general population or among litigants claiming a psychological injury.

**Holmes-Rahe Social Readjustment Rating Scale**

The Holmes-Rahe Social Readjustment Rating Scale, or what is sometimes called the “Life Changes Scale,” is a list of 43 potentially stressful events that can occur in a person’s life. The scale is administered by having the person check all of the 43 items that have occurred in their life in the last year (Holmes & Rahe, 1967). Each event has an associated “Life Change Unit,” a number that varies between 11 and 100. The more stressful the event is believed to be, the larger the number. For example, the death of a spouse is given a score of 100. Divorce is given a score of 73. Pregnancy is given a score of 40. A change in working hours or conditions is given a score of 20. To get a measure of the “stress” in a person’s life, a total of the checked items is obtained. While the person’s total score is thought to be related to the likelihood of that person developing a physical illness, research has indicated that any such relationship is modest. Regardless, some psychologists use this rating technique to try to get an overall measure of how stressful an individual’s life has been in the last year. However, there is no known ability of the Holmes-Rahe Social Readjustment Rating Scale to assess DSM-IV-TR psychopathology in a forensic context.

**Hooper Visual Organization Test (HVOT)**
The Hooper Visual Organization Test (HVOT) was originally developed to identify organic brain conditions or neurological impairment in mental hospital patients (Hooper, 1993). It is currently thought of as a neuropsychological test of visual spatial ability or visual integration. In administering this test the individual is presented with thirty cut-up pictures of relatively easily identifiable line drawings of objects and asked to identify the object’s name. The test is known to rapidly assess an individual’s capacity to recognize objects by partial cues and to abstractly organize one’s perceptions into a meaningful whole. Although it has been presented in some contexts as being capable of assessing cognitive ability, the test does not correlate significantly with intelligence except at lower levels of intellectual abilities. The HVOT is sometimes used in psychological examinations where it may be of interest to eliminate the possibility that a person’s clinical presentation is due to a neurological disorder. However, the publishers of the test point out that the HVOT is intended as a screening device of only the specific area of visual integration and should not be used in isolation but as part of a more intensive neuropsychological test battery. Additionally, since there are no methods to assess truthfulness, beyond possibly using the HVOT to assist in screening for organic brain damage, the HVOT is of no known use in providing information about psychopathology in a medical-legal context.

**House-Tree-Person Test (HTP)**

The House-Tree-Person Test (HTP) is a projective test in which the test-taker is asked to draw at least one house, one tree, and one person. The test has both objective and subjective scoring methods. When it is administered in conjunction with an attempt to obtain information about personality or psychopathology it is scored in a subjective manner. When scored objectively or quantitatively, the drawings are analyzed in details that provide an assessment of intelligence. Administration and scoring in this manner takes more than two hours to yield scores that can be obtained much more quickly using other instruments. Hence, the HTP is almost no longer ever used to assess intelligence. Currently, the primary use of the HTP is for personality assessment. In these cases the test administrator subjectively interprets the drawings and the answers to
questions they may have posed. One such interpretation might be if the person draws a small house that might be an indication of a rejection of one's home life. Clearly, as is true of other subjectively interpreted tests, there is little support for interpretations of this nature. As such, the HTP has little utility in medical-legal evaluations.

**Inwald Personality Inventory**

The Inwald Personality Inventory was expressively developed as a personnel test to assist administrators in the effective selection of prospective law enforcement officers. The test consists of 310 true-false items designed to produce information about 26 different variables. The research literature appears to indicate that the test can effectively evaluate law enforcement applicants. However, there are no data in the psychological literature that indicate that the test is effective in assessing psychopathology in litigants claiming a psychiatric injury.

**Inwald Survey 5-Revised**

The Inwald Survey 5-Revised is an assessment device that uses 192 true-false items in pre-employment screening for public safety personnel to identify individuals most qualified for the positions. Unfortunately, this instrument has no known validity or reliability with regard to assessing psychopathology in the general population or in individuals who have alleged that they have suffered a psychological injury. As such, its use in a medical-legal context has no known basis.

**IPAT Anxiety Scale**

This test is a 40-item questionnaire intended to measure anxiety. In this test the individual is presented with 40 declarative statements and asked to pick one of three alternatives that they believe is most true of them. For example, one similar item that is not on the test itself is the statement, “I enjoy walking.” The person then has to pick between (a) yes, (b) sometimes and (c) no.
Unfortunately, an inspection of the testing manual indicates that there are no validity scales for this instrument (Krug, Scheier, & Cattell, 1963). In fact, the authors of the test appear to have taken refuge from a criticism of the instrument on this basis by stating, “we can never be sure the answers we receive to questions we ask are true, precise, or complete.” However, this begs the real question, which is, how likely is the person to have completed the test in an honest and frank manner? Clearly, the authors made no attempt to devise a method for providing an answer. Accordingly, there is no method for assessing the truthfulness of the individual’s responses and therefore the test is useless in a medical-legal context with regard to determining if an individual is suffering from pathological anxiety.

**IPAT Depression Scale**

The IPAT Depression Scale is a 40-item questionnaire that is intended to measure clinical depression. Like the IPAT Anxiety Scale, the individual is presented with 40 declarative statements and asked to pick one of three alternatives that they believe is most true of them. For example, the statement, “I prefer friends who are:” is the beginning of one item. Having presented that statement, the person taking the test has to pick one of three alternatives, (a) quiet, (b) in between, and (c) lively. Unfortunately, an inspection of the testing manual indicates that there are no validity scales for this instrument (Krug & Laughlin, 1976). In fact, much like the IPAT Anxiety Scale testing manual, the authors take refuge behind the statement “any time we ask someone a question……we have no assurance at all that the answer is correct.” However, once again, this begs the real question, which is, how likely is the person to have completed the test in an honest and frank manner? Clearly, the authors made no attempt to devise a method for providing an answer. Accordingly, with no method for assessing the truthfulness of the individual’s responses, this instrument is not capable of providing any meaningful information about the possible existence of a Depressive Disorder in the context of a medical-legal examination.

**Malingering Probability Scale**
The Malingering Probability Scale purports to be a measure of individuals who are attempting to simulate depression, a Dissociative Disorder, a Posttraumatic Stress Disorder or Schizophrenia. The test is composed of 139 declarative true-false questions. Examples of the type of items, but ones that do not appear on the test are, “I sometimes forget my telephone number” and “I have a poor appetite.” There are also six pairs of questions that have similar content that are used to determine if the person has responded to the test in a consistent or inconsistent manner. If it is found that the person responds to five of the six pairs of items in an inconsistent manner, the authors of the test state that this raises “serious doubts” about the meaningfulness of that person’s results (Silverton, 1998). As their statement indicates, there are no methods for clearly discriminating between people who have responded truthfully and those who have not. Unfortunately, a search of the PsycINFO database maintained by the American Psychological Association reveals no references to any published research on the Malingering Probability Scale appearing in any refereed journals in the psychological literature. In the absence of such research, this seemingly promising test has yet to be demonstrated as being capable of providing credible information about malingering.

McGill Pain Questionnaire

The McGill Pain Questionnaire was developed in 1975 by Dr. Ronald Melzack, a psychologist, and has been cited in numerous professional journal articles in the psychological literature (Melzack, 1975). Individuals taking this questionnaire rate their pain on how it feels, how strong it is and how it changes with time. The test also inquires about circumstances that increase or decrease the pain. The ratings are then converted into numerical scores that vary from 0 to 78 such that the higher the number, the greater the pain. However, despite the conversion of the subjective ratings to a numerical rating scale, the numerical score is still a subjectively generated quantity. Additionally, the McGill Pain Questionnaire has no validity scales that are needed to assess an individual’s test-taking attitudes and credibility. There is also no known relationship between scores on the questionnaire and DSM-IV-TR diagnoses. Thus, while the McGill Pain Questionnaire can generate rating scale scores
expressing an individual’s subjective perception of their pain that may be useful in treatment to assess improvement over time and in research to test various theoretical hypotheses, it has not been shown to be an effective diagnostic instrument. Clearly, in the context of a medical-legal examination this instrument is not capable of providing any relevant data about the possible existence of psychopathology.

**Memory for Designs Test**

[See the Graham-Kendall Memory for Designs Test]

**Mental Status Evaluation Checklist**

One “test” that has shown up on a number of medical-legal evaluations from psychologists and psychiatrists in the Southern California area is the Mental Status Evaluation Checklist. However, attempts to obtain data about this instrument have been fruitless. In particular, a review of the literature on psychological testing conducted through the PsycINFO, the database system maintained by the American Psychological Association, revealed no published research articles on the Mental Status Evaluation Checklist. Accordingly, this test has no known validity or reliability and therefore, no known relationship to psychopathology in a medical-legal context. It appears likely that this instrument is the creation of one or more of a group of doctors who have not published any research or made known in any other manner the reliability or validity of this instrument for determining psychopathology in a medical-legal context.

**Miller Forensic Assessment of Symptoms Test (M-FAST)**

The Miller Forensic Assessment of Symptoms Test (M-FAST) is not a psychological test in the sense that it presents any physical material that is administered to a patient. Instead, the M-FAST is a 25-item, doctor-administered, brief structured interview designed to identify individuals who may be over-reporting, exaggerating, or fabricating psychological symptoms. A review of the 19 published
studies that were available at the time of this writing indicates that interviewing an individual using the items on the M-FAST appears to produce information that correlates with other measures of malingering. As such it is likely that the M-FAST is an effective interview technique for identifying individuals who are attempting to simulate symptoms. However, the M-FAST is clearly not capable of presenting any non-interview objective data to the court.

**Millon Clinical Multiaxial Inventory-III (MCMI-III)**

The Millon Clinical Multiaxial Inventory-III (MCMI-III) is the most recently revised version of the Millon Clinical Multiaxial Inventory. Dr. Theodore Millon, a specialist and pioneer in the area of Personality Disorders, originally devised this test. The test is expressly intended to provide information about individuals who are known to have psychological problems. The MCMI-III is composed of 175 true-false items that are in the form of declarative statements. Similar items that do not appear on the test are, “At times I have trouble getting along with my family” and “I enjoy a wide range of activities.” The person’s responses to the items are scored on 28 scales. The scales are composed of different numbers of items from the pool of 175. Fourteen of the scales provide information about Axis II Personality Disorders, ten provide information about Axis I disorders and four provide information about the validity of the test taker’s responses. The data from the four validity scales assess: (1) “Validity” - Did the individual understand and attend to the content of the questions? (2) “Debasement” - Did the individual attempt to portray him or herself as having more troublesome emotional and personal difficulties than exist? (3) “Desirability” - Did the individual attempt to portray him or herself as being more morally virtuous, socially attractive and more emotionally well composed than they are? and, (4) “Disclosure” - Was the individual inclined to be frank and self-revealing or more likely to be secretive? If for no other reason, the presence of the validity scales makes the test potentially useful in medical-legal cases, as it allows for conclusions to be drawn about truthfulness and credibility, which if established, permit confidence in the clinical statements to be arrived at from an interpretation of the remaining 24 scales.
Unfortunately, the MCMI-III presents a major problem that limits the usefulness of the test in medical-legal evaluations where the major question is “Does the person have a disorder?” In this regard, Dr. Theodore Millon, the well known author of the test, has explicitly stated that the “normative data and transformation scores” for the MCMI are based on individuals with known psychopathology, and therefore the test is applicable only to individuals who have already been identified as having pre-existing psychiatric disorders (Millon, Millon, & Davis, 1994). Clearly, under these circumstances the MCMI is not appropriate in medical-legal cases where the first question that is typically asked about the person being evaluated after establishing their credibility is whether or not they have a DSM-IV-TR disorder. Apparently, Dr. Millon does not believe that the MCMI is useful in providing data capable of distinguishing between normal and abnormal individuals, but is most appropriate for determining the specific nature of Personality Disorders and other Axis I disorders in individuals previously identified as having psychopathology.

**Millon Index of Personality Styles (MIPS)**

The Millon Index of Personality Styles (MIPS) is a 180-item true-false test that was explicitly designed for use in assessing the personality traits and attributes of a non-clinical or normal population. If the individual is known to have some psychopathology, the MIPS should not be used but the person should be given the Millon Clinical Multiaxial Inventory-III. Seemingly, if there were uncertainty about the existence of psychopathology, neither the MCMI-III nor the MIPS would appear to be an appropriate test to administer. Nevertheless, when scored, the MIPS produces information about the individual on twelve bipolar or diametrically opposed traits. For example, six of the pairs of these oppositional traits are retiring vs. outgoing, thinking vs. feeling, hesitating vs. asserting, dissenting vs. conforming, yielding vs. controlling, and complaining vs. agreeing. In this regard, a person who is designated as “hesitating” would be found to be uncertain and fearful, unsure of their personal worth, have feelings of insecurity, and be likely to withdraw socially. Contrast this with a person who is found to be “asserting” who would be socially confident, self-possessed, bold, and decisive in relationships. While not employed in a clinical setting, the MIPS is frequently used in personnel selection
and development as well as career planning. As noted above, since the test is not designed to assess psychopathology, it has no use in determining if a plaintiff in a medical-legal case has or has had a psychological disorder.

**Millon Behavioral Health Inventory (MBHI)**

The Millon Behavioral Health Inventory (MBHI) is a 150 true-false test that was not designed to diagnose psychopathology but to provide health-care workers with information about an individual's style of coping with health issues. While some psychologists have used this instrument for diagnostic purposes, the test's items are highly transparent in the sense that even a psychologically unsophisticated person would have little difficulty determining which choice is consistent with a psychological illness. For example, one such item states, “I have had more than my share of troubles in the past year.” Additionally, an inspection of the testing manual reveals that there are no methods for scoring the test that are capable of determining if the individual is, in the words of the test authors, attempting to “complain excessively” (Millon, Green, & Meagher, 1982). Accordingly, if used in a forensic setting, the data from the Millon Behavioral Health Inventory are uninterpretable and cannot provide any data concerning the possibility that the patient was suffering from psychopathology when examined by the doctor.

**Millon Behavioral Medicine Diagnostic (MBMD)**

The Millon Behavioral Medicine Diagnostic (MBMD) is a 165-item true-false, paper-and-pencil, audiocassette, or computer administered test intended to assess psychosocial factors that may either support or interfere with a physically ill patient's course of medical treatment. The primary purpose of the MBMD is to provide information to clinicians, including psychologists, medical doctors and nurses, who deal with physically ill patients, about any thoughts, feelings and behaviors that might affect their medical illnesses. In this regard, the test is said to provide information that can help formulate a comprehensive treatment plan, provide information regarding a patient's style of relating to health-care professionals, and
delineate problematic psychosocial attitudes and stressors. More specifically, the MBMD provides information about negative healthcare habits, such as drug and alcohol use, the individual’s style for coping with problems, the existence of some psychiatric symptomatology, the sources of stress in the individual’s life, and information to consider in managing and treating the patient. One of the advantages of the MBMD is that like the MCMI it has validity scales that can detect individuals who are either not willing to engage in self-disclosure or are trying to depict themselves in an unrealistically negative or positive light. Unfortunately, there is relatively little information in the published psychological testing literature on the MBMD. Thus, while the MBMD may help health-care professionals to provide for their patients, it is not capable of serving as a diagnostic test useful in assessing DSM-IV-TR psychopathology.

**Minnesota Multiphasic Personality Inventory (MMPI)**

The Minnesota Multiphasic Personality Inventory (MMPI) is the most widely researched and used instrument in clinical psychology. The senior author of the test is Dr. Stark Hathaway, who I am very proud to say I had the great honor of meeting and learning from when we were on the faculty at Ohio University in the middle 1960s. Much to its credit, the MMPI has been in clinical use for almost 70 years. During this time, hundreds of books and thousands of research articles have been published demonstrating that the test is a valid and reliable measure of personality and psychopathology. It is this body of literature that gives the test its credibility in a medical-legal context. The test itself consists of 566 true-false questions. Versions are available in multiple languages. This MMPI is usually the keystone of all clinical psychological test batteries where the major question concerns the presence or absence of DSM-IV-TR psychopathology. In this regard, the MMPI is able to provide information about psychopathology, the test-taker’s basic personality, their credibility, as well as how they are functioning in the world.

The MMPI is especially useful in forensic evaluations because of its ability to use a variety of validity scales to detect attempts to simulate psychological symptoms. In this area, a significant advantage of the MMPI is that the test items are not transparent.
Even psychologically sophisticated individuals are unable to perceive the true intent of the test items. This makes the MMPI relatively hardy in its ability to thwart and detect simulation. While there are a very large number of studies that demonstrate the ability of the MMPI to detect an attempt at simulating symptoms, I can provide a more anecdotal indication of its strength in this area.

During my tenure at San Diego State University I had an opportunity to teach a graduate level course in clinical psychology. Part of the purpose of that class was to familiarize students with psychological tests, including the MMPI. As part of the familiarization process, I assigned the students to take the MMPI at home. This is something that I would never do if I wanted to draw some conclusions about the test-taker’s psychological status, since the MMPI requires a test proctor to guarantee that the test is taken under standardized conditions. However, in this case what I did was permissible because I did not want any information about the student’s psychological status. In fact, it would have been unethical to give the students the MMPI under standardized conditions because they were a captive audience, who might not want to take the test for a variety of reasons, including the possibility that it might reveal something that they might not want to hear about or to have disclosed. Thus, I asked them not to take the test honestly, but to attempt to fake a disorder. This allowed the students to take the MMPI without putting them or me in a compromising position. Now in order to put a little variety into my life, each semester I taught the course I would ask the class to try to fake a different disorder. One semester I might ask them to try to fake a Major Depressive Disorder and the next a Generalized Anxiety Disorder, or perhaps a Dependent Personality Disorder or Schizophrenia. Additionally, although these students were reasonably psychologically sophisticated, I tried to stack the deck in their favor by asking them to supplement whatever knowledge they had about the assigned disorder by studying the disorder’s criteria in the diagnostic manual. When I started this exercise I suspected that at least some of the students would be able to fake a disorder successfully. However, although I had about 30 students each semester, I never had a single student who did not get caught trying to fake. Not one!
There are multiple validity scales on the MMPI that can be used to assess frankness, honesty and attempts to simulate symptoms. In this regard, the Lie (L) Scale has been shown to be effective in detecting individuals who are not being honest and frank. The F Scale, the F-K Scale or Index and the Revised Dissimulation Scale have been shown to be effective in detecting individuals who are trying to appear to have symptoms that do not exist. Additionally, the Test-Retest Scale and a Carelessness Scale have been shown to be able to detect individuals who are not responding consistently to the items, a phenomenon observed in individuals who are trying to distort their true psychological condition and are unable to maintain a consistent pattern of scoring during the relatively long MMPI testing session. There is also a Cannot Say Scale that is a simple total of the number of questions not answered.

With regard to the Cannot Say Scale, it is public knowledge that if the person does not answer more than 30 of the questions, it is not reasonable to interpret their clinical scale scores and say anything about their psychological status. While I do not have any hard data concerning this issue, for a long time I have believed that some of the people sent to my office for an evaluation have been coached or have found out that this is true, and have deliberately not answered more than 30 of the questions. However, what they seemingly do not know is that the 30-question criterion only applies to the clinical scale scores, not the validity scale scores. So unless they are honest in responding to the questions they answer, the test may show that they are not being honest and frank or attempting to simulate symptoms. It has been my experience that more often than not, the people who don’t answer a large number of questions are also found not to be answering the remainder in a credible fashion.

One of the most important features of the MMPI is that it is empirically based. Additionally, as noted above, the items on the MMPI are not transparent. That is, there is no particular understandable logic or connection between any given question and the test’s results. Perhaps this is best exemplified by a sample question that does not appear on the MMPI but serves as a good illustration. Imagine a question on the MMPI that reads, “I prefer the Queen of Hearts to the Jack of Diamonds.” Clearly, this question cannot be reasonably interpreted by the test-taker as having any
connection to any particular disorder or personality characteristic. This empirical basis for the MMPI questions makes it especially difficult to simulate symptoms because, as some patients have explicitly stated, “I don’t like this test because I can’t figure out what they are getting at (want).” Nevertheless, as discussed earlier, the test has been shown by thousands of research articles published in the psychological testing literature and hundreds of books as being capable of assessing psychopathology because of the known relationship between the answers to the items and psychopathology.

With regard to the mechanics of interpreting the MMPI, as noted above, once the individual has completed the test items they are scored on a variety of validity scales that can determine if the individual has completed the test in an honest and straightforward manner. If their performance indicates that they have done so, it is reasonable to interpret the 10 basic clinical scales as well as a variety of supplemental scales that have been published since the test’s inception, some 60+ years ago. The clinical scales are scores obtained from groupings of questions that are capable of providing information about a person’s personality traits and/or psychopathology. In interpreting these clinical scales, there are multiple books and research articles that indicate what they mean. The method that is universally accepted for the interpretation of the MMPI is to look at the highest two or three clinical scale scores. Research has convincingly demonstrated that there is a known relationship between the pattern of these scores and DSM-IV-TR psychopathology (e.g., Greene, 2000; Meyer, 1982).

Given all of the above, it is easy to understand why the MMPI should be the cornerstone of every medical-legal test battery.

**Minnesota Multiphasic Personality Inventory-2 (MMPI-2)**

The Minnesota Multiphasic Personality Inventory-2 (MMPI-2) is the 1989 revision of the MMPI. As the authors of the revision pointed out in the testing manual for the MMPI-2, the motivation for changing the test was, in part, concern about questions that were labeled as having “sexist wording, outmoded idiomatic expressions, and references to increasingly unfamiliar literary material and recreational
activities” (Hathaway & McKinley, 1989). In fact, a comparison of the MMPI and the MMPI-2 reveals that there were relatively few items that fell into these categories. Another reason that was given for the revision was the comment that the MMPI was standardized and norms collected on a sample of people who were not representative of the 1989 population of the United States. However, this comment bears little weight as over the years the MMPI has been shown to be applicable, valid and reliable with a wide variety of populations from highly diverse backgrounds (e.g., Cheung & Song, 1989).

Nevertheless, the MMPI was revised and became the MMPI-2. However, it should be noted that in changing the test only 13 items from the original MMPI were deleted and only 87 were changed to some degree, with many of those questions showing only minor changes. There was also a net increase of one item as the MMPI-2 has 567 questions compared to the 566 on the MMPI. Thus, of the 566 items on the MMPI the 100 that were changed to some extent or deleted constitute only a little less that 18% of the items! Or, alternately, 82% of the MMPI was retained. Regardless, there is substantial evidence that the resulting MMPI-2 is not as good an indicator of psychological status as the MMPI.

Despite the changes in the MMPI-2 questions, the basic procedures for test administration and interpretation are the same for both the MMPI and the MMPI-2. After the person completes the 567 true-false items the answers are scored to provide a set of validity scale scores, to assess the individual’s credibility, and a set of clinical scale scores to provide information about their personality and psychopathology. If the validity scales show that the person has been honest and frank and has not attempted to distort their clinical presentation, the clinical scales can be used to look for the presence of personality characteristics and psychopathology.

With regard to the validity scales, there is still an F Scale, an F-K Scale or Index and a Lie (L) Scale. The F Scale and the F-K Scale are capable of assessing individuals who are attempting to simulate symptoms. The Lie (L) Scale detects people who are answering the questions in less than an honest and frank manner. However, the MMPI-2 eliminated some of the questions on the Revised Dissimulation Scale, although there are data in the psychological
literature indicating that the remaining items provide a good measure of whether the individual has attempted to simulate symptoms (Leckart, 1994). In addition, there were further changes to the validity scales in that the Carelessness Scale and the Test-Retest Scale were eliminated and replaced by the VRIN Scale, their statistical equivalent. Most interestingly, since the publication of the MMPI there has been additional research that has produced two important validity scales capable of detecting attempts to simulate symptoms. These scales are the F(p) Scale and the F(Back) Scale (Arbisi & Ben-Porath, 1998; Sivec, Lyons, & Garske, 1994). Thus, the MMPI-2 retains its ability to detect the test-taker's credibility.

The procedures for interpreting the clinical scales and coming up with some conclusions about the existence of psychopathology and personality are the same for the MMPI and the MMPI-2. Accordingly, the authors of the MMPI-2 maintain that individuals who receive patterns of scoring on the highest two or three clinical scales are known to share and have certain psychiatric characteristics, some of which are psychopathological. Unfortunately, the research that has been conducted on the MMPI has not been shown with any vigor or clarity to be transferable to the MMPI-2.

As discussed above, once an individual has been demonstrated to be taking the MMPI-2 in an honest fashion, the next step is to interpret the clinical scale scores. In this regard, the method that is universally accepted for the interpretation of the clinical scales is first to determine the highest two or three clinical scale scores or what are called "code types." The next step is to make statements about the person that are based on the known relationship between the pattern of these scores or code types and an individual's psychological status. Thus, for example, the most likely diagnosis for a person who receives their highest two clinical scale scores on Scales (2) and (6), or presents with what is said to be a 2-6 code type, is a Borderline Personality Disorder. However, research has indicated that the interpretation of the code types established by the 60+ years of research on the MMPI may not be applicable to the MMPI-2. This raises a serious question as to the meaning of clinical scale elevations on the MMPI-2. Support for this conclusion comes from numerous investigators who have studied the problem and found relatively little agreement between scores on the MMPI and those on
the MMPI-2 (e.g., Edwards, Morrison & Weissman, 1993). Most importantly, Dr. Roger L. Greene, an independent researcher who is not an author, publisher or distributor of the MMPI, summarized the literature by explicitly stating in his major work on the MMPI-2 that, “studies of the correlates of specific MMPI-2 code types still are very sparse given that the MMPI-2 has been in existence for almost a decade” (Greene, 2000). More recently, Dr. David Fox, an expert in forensic psychological testing drew a comparable conclusion about the interchangeability of MMPI and MMPI-2 code types (Fox, 2008). Thus, as of this writing, the psychological testing literature, in the form of empirical data on the MMPI and the MMPI-2, continues to support the conclusion that the use of the MMPI represents a much more conservative approach to psychopathological assessment than the use of the MMPI-2.

Data that further support the conclusion that the MMPI is preferable to the MMPI-2 for use in medical-legal examinations comes from the test publishers, the University of Minnesota Press. Specifically, in July, 2008 they released a modified version of the MMPI-2 called the MMPI-2-Restructured Form (MMPI-2-RF) in July, 2008. The MMPI-2-RF has been reported as being based on what are called the Restructured Scales (RC Scales) that the test distributor, Pearson Assessments in Bloomington, Minnesota, states “provide a more clearly focused interpretation” of the clinical scale scores (Pearson Assessments, 2008). The development and use of these RC Scales are described at length by Tellegen, Ben-Porath, McNulty, Arbis, Graham, & Kaemmer (2003). Unfortunately, the use of the RC Scales has not been met with anything approaching universal approval. Essentially, there is currently an unresolved controversy in the psychological testing literature as to how to interpret the MMPI-2. Moreover, the publication of the Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF) in July, 2008 is not helpful, as that will only begin the needed process of independent research conducted by professionals who are not associated with the publication, distribution, marketing or sale of the test. In short, it appears to me that the publication of both the RC Scales and the MMPI-2-RF is tantamount to admitting that the MMPI-2 was not adequate and needed help. Unfortunately, I believe that the help will not be forthcoming for at least the many years that it will take to do the independent research that needs to be done. Until that
time comes, if it does, the MMPI will maintain its prominence and superiority in the assessment of personality and psychopathology.

**MMPI-168**

The MMPI-168 is a not a “test” in and of itself but a particular use of the MMPI that has some serious problems. For example, the MMPI-168 involves administering only the first 168 items of the 566-item MMPI, or only 30% of the test items. The difficulties involved in using shortened versions of the MMPI are quite readily apparent. Without doubt, shortened versions of the MMPI do not allow for the assessment of the validity of the test administration. Many of the questions needed to score the Lie (L) Scale, the F Scale, the K Scale, the Test-Retest Scale, the Carelessness Scale and the Revised Dissimulation Scale are not contained in the first 168 items of the MMPI. All of these scales are needed to determine if the patient has completed the MMPI in an honest and forthright manner. Since it is well known that the first consideration in interpreting MMPI scores is assessing credibility, the administration of the MMPI-168 in a medical-legal case is clearly unwarranted. Additionally, psychologists have long been aware that “shortened MMPI scales have been considered to be too inaccurate to use in clinical evaluations” (Butcher & Hostetler, 1990). Thus, the use of the MMPI-168 in a medical-legal examination represents a substantial flaw in that evaluation.

**MMPI-370**

The MMPI-370 is a shortened version of the MMPI-2 that is analogous to the MMPI-168. Like the MMPI-168, the MMPI-370 is not a “test” in and of itself but a particular use of the MMPI-2 that has some serious problems. The MMPI-370, as the name implies, involves administering the first 370 questions of the MMPI-2. This allows for the scoring of the Lie Scale, the F Scale, the K Scale, the F-K Scale or Index and the 10 basic clinical scales. If you assume that the MMPI-2 is a valid and reasonable instrument to use, the scoring of these scales may be acceptable in a general clinical practice where it can be assumed that the person does not have a deviant test-taking attitude. However, in a medical-legal context this
is not a reasonable assumption and it is necessary to score at least the F(p) Scale, the F(Back) Scale, the VRIN Scale and the Revised Dissimulation Scale to determine if the person is responding in an honest and frank manner and not attempting to simulate dysfunction. Unfortunately, it is not possible to score these scales if the person responds to only the first 370 items on the MMPI-2. Therefore, the MMPI-370 is virtually useless in forensic circumstances.

**Mooney Problem Checklist**

The Mooney Problem Checklist is a list of potential personal problems that is presented to an individual to either endorse or deny. The checklist was developed by asking individuals in various demographic groups to list problems that they have encountered in their lives. The expressed purpose of the checklist is to identify personal problems in adolescents and adults that can then be addressed in group meetings or individual counseling sessions. The areas surveyed are health and physical development; home and family; morals and religion; courtship, sex, and marriage. Unfortunately, there is nothing in the psychological literature that indicates that this instrument is valid or reliable for assessing psychopathology in a medical-legal context. Moreover, as with other problem checklists, their use in a forensic context is undesirable as the presentation of the checklist itself can be an encouragement to claim problems that do not exist.

**Multidimensional Pain Inventory**

The Multidimensional Pain Inventory (MPI) has also been called the West Haven-Yale Multidimensional Pain Inventory (WHYMPI). It was designed to obtain information about chronic pain patients. It is a 61-item self-report measure in which the person is asked to respond to three different sets of items of 28, 14, and 19 items, respectively. The first set of items deals with the extent of the patient’s self-perception of their pain and how it has affected their relationships. The second set of items deals with the patient’s perception of how their significant other deals with the patient when the partner knows the patient is in pain. The third set of items deals
with the frequency of the patient’s daily activities. In each case the items are responded to on a seven-point scale, the nature of which depends on the item. An example that does not appear on the test is, how nervous are you when you ride in a car when the traffic is heavy? The person is asked to rate their nervousness on a scale from 0 to 6 with 0 defined as “Not at all Nervous” and 6 defined as “Extremely Nervous.” Essentially, the individuals rate themselves on a six-point scale inquiring about their pain, how their spouse or significant other responds to their pain and the frequency with which they engage in everyday activities. On the basis of the scores patients can be classified as falling into one of three categories: “dysfunctional,” “interpersonally distressed,” and having an “adaptive coping style.” Unfortunately, this instrument does not have any validity scales for detecting an individual’s test-taking attitudes or credibility, and therefore, in a medical-legal context, the results cannot be taken at face value as providing any credible information about the test-taker or their actual experience of pain. Moreover, the test is only intended to provide information about an individual’s pain, and in the absence of a DSM-IV-TR Pain Disorder diagnosis it is clearly irrelevant in assessing any other possible DSM-IV-TR psychopathology.

**Multiscore Depression Inventory**

The Multiscore Depression Inventory is a self-report questionnaire consisting of 118 true-false questions that is said to provide information on the existence of an individual’s overall level of depression as well as data on 10 factors related to depression such as low self-esteem, low energy level, pessimism and irritability. The test is said to be especially useful with normal individuals as the MDI was originally designed for, tested and normed on a non-clinical population. The test has a scale for assessing truthfulness but a survey of PsycINFO reveals that while at the time of this writing this instrument has been used in 34 research projects, there are no published data in peer-reviewed journals indicating that this test has any validity scales capable of assessing the credibility of an individual’s responses. Accordingly, this instrument cannot provide any credible information about an individual’s psychiatric status in the context of a medical-legal examination unless there is independent
evidence from some other source indicating that the person has approached the evaluation in an honest and frank manner.

**NEO Personality Inventory-Revised (NEO PI-R)**

The NEO Personality Inventory-Revised (NEO PI-R) is a measure of what the developers of the test state are normal personality traits. The traits were determined by factor analytic studies that are said to have determined that the traits are Extraversion, Agreeableness, Conscientiousness, Neuroticism, and Openness to Experience. The test exists in two forms, Form R and Form S. Form R uses observer ratings and is for use when the person examined is incapable of completing the inventory, or when there is reason to believe they are “highly motivated to falsify responses.” However, since there is very little chance that an observer will have ample opportunity to provide credible observations of the person being evaluated in a forensic situation, we can dismiss Form R from our consideration and focus on Form S. Form S uses the person’s responses to 240 items. An example that is not actually part of the test might read, “I like having friends who are fun.” The person then answers by picking one of five alternatives that corresponds to the strength of their agreement with the statement: “strongly agree,” “agree,” “neutral,” “disagree” and “strongly disagree.” The items are objectively scored and the individual is reported as having more or less of each of the five different personality traits. Unfortunately, there is only a single question included with the test that is said to provide a measure of the person’s truthfulness in answering the questions. This question asks if the individual has answered the other items in an honest and accurate manner. While this manner of determining truthfulness may be useful in a non-forensic setting, it is obviously useless in a medical-legal evaluation and therefore there is no method of determining the credibility of the person’s responses or stating anything about their psychological status.

**Neuropsychological Impairment Scale (NIS)**

The Neuropsychological Impairment Scale (NIS) is a 95-item self-report screening measure of neuropsychological and emotional
symptoms as well as test-taking attitudes. Eighty of the items solicit information about neuropsychological symptoms, ten items ask about emotional symptoms and 5 items ask about test-taking attitudes. On each item the person rates him or herself on a five-point scale according to how frequently each described issue occurs. As such, this rating scale is used to assess complaints of individuals who have or are suspected of having neurological problems. However, a search of the PsycINFO database reveals that as of this writing there are only sixteen references concerning this instrument spread out between 1987 and 2008. An inspection of those documents revealed no data indicating that the Neuropsychological Impairment Scale has any validity or reliability with regard to assessing psychopathology in a medical-legal context. Thus, while it is conceivable that this instrument may produce information relevant to neurologists evaluating neurological disabilities, there are no data indicating it is relevant to assessing a psychiatric injury.

**Neuropsychological Questionnaire**

One test that has shown up on a number of medical-legal psychological evaluations from psychologists and psychiatrists in the Southern California area is the Neuropsychological Questionnaire. However, attempts to obtain data about this instrument have been fruitless. A review of the PsycINFO database reveals two published articles on the Neuropsychological Questionnaire (Dean, 1982; Reynolds, 1983). Unfortunately, neither of these studies provides any information indicating that the Neuropsychological Questionnaire is capable of assessing either psychopathology or an individual’s credibility. As such, it is not useful in a medical legal examination designed to determine if someone has had a psychological injury.

**Neuroticism Scale Questionnaire**

The Neuroticism Scale Questionnaire is a frequently used 40-item questionnaire purporting to measure “neurotic tendencies.” The authors begin by stating that six personality dimensions or characteristics have been identified by factor analytic research as accounting for most of the differences between individuals judged by
mental health clinicians to be normal and those judged to be neurotic. Having done so, they posed a series of 40 questions that take aim at those personality dimensions. In each test question the person is presented with a declarative statement and asked what they do and how they feel about the situations presented in those questions. For example, one similar item that is not on the test itself is the statement, “I like to go swimming.” The person then has to pick between (a) Yes, (b) In-Between and (c) No. Unfortunately, an inspection of the testing manual indicates that there are no validity scales for this instrument (Scheier & Cattell, 1961). Accordingly, no credible data can be obtained from this instrument with regard to either the individual’s test-taking attitudes or credibility or the possibility that they have ever had a psychological disorder.

**Oars Multidimensional Functional Assessment Questionnaire (OMFAQ)**

The Oars Multidimensional Functional Assessment Questionnaire (OMFAQ) is the shorthand way of referring to the Older Americans Resources Program Functional Assessment Questionnaire. This questionnaire was developed at the Duke Center for the Study of Aging and Human Development at the Duke University Medical Center, and was specifically designed as a means of determining the impact of services and alternative service programs on the functional status of older persons. It was not intended as a measure of DSM-IV-TR psychopathology and its usefulness for that purpose is, to say the least, dubious.

Essentially, the Oars Multidimensional Functional Assessment Questionnaire (OMFAQ) is a questionnaire that has been used exclusively with the elderly and is administered by having the examining clinician subjectively rate the individual on a six-point rating scale in areas identified as Social Resources; Economic Resources; Mental Health; Physical Health; and Self-Care Capacity. The rater also obtains information on the elderly person’s Basic Demographics, as well as collateral information from “informants” concerning the person’s status in the above-noted areas. The first section of the OMFAQ seeks information on five dimensions of functioning: Social Resources, Economic Resources, Mental Health,
Physical Health, and ability to carry out Activities of Daily Living. On each dimension the information obtained is summarized on a 6-point scale where the ratings range from 1 (level of functioning excellent) to 6 (level of functioning totally impaired). There are a total of 101 questions, although the mental health segment of the OMFAQ contains just six questions devoted to assessing organicity; extent of worry, satisfaction and interest in life; and the measurement of present mental status and change in mental status in the past five years. In recognition of the complexity of the assessment process, the Aging Center at Duke University offers a video training tape to assure consistent and reliable data collection. Clearly, based on the purpose of the test, the need for specific training in collecting the data, the relatively small segment of the population the instrument is intended to deal with and the relatively small amount of mental health data collected, at best this test is of limited use in forensic examinations. Given the subjectivity of the “testing” process and the presence of alternate tests for assessing psychopathology, such as the MMPI, there is no reason to suspect that the OMFAQ would be a generally useful tool for assessing psychopathology in medical-legal litigation.

**Occupational Stress Inventory-Revised**

The Occupational Stress Inventory-Revised (OSI-R) is a battery composed of three questionnaires: the Occupational Role Questionnaire (ORQ), the Personal Strain Questionnaire (PSQ) and the Personal Resources Questionnaire (PRQ). These are said to measure occupational stress, psychological strain and coping resources. The OSI-R is comprised of 140 items on which the respondents rate themselves on a 5-point scale according to the frequency with which they believe an event described in the items occurs. High scores on the ORQ and the PSQ are said to “suggest” significant levels of occupational stress and psychological strain, respectively. High scores on the PRQ are said to indicate highly developed coping resources. Unfortunately, the testing manual reveals that there is no method in this inventory for assessing the truthfulness of an individual’s responses (Osipow & Sokane, 1992). Additionally, a search of the PsycINFO database maintained by the American Psychological Association reveals no evidence of any
research indicating that the OSI-R has any validity or reliability with regard to assessing psychopathology in a medical-legal context.

**Personality Assessment Inventory (PAI)**

The Personality Assessment Inventory (PAI) is a self-report test that was first published in 1991 and contains 344 easy to understand declaratory statements. An example of such a statement that does not actually appear on the test is, “I think I am a valuable person.” Using a four-point scale test takers rate how true or false each statement is about them. These responses are used to produce scores on 11 clinical scales, 4 validity scales, 5 treatment consideration scales and 2 interpersonal scales. Although the test does not provide any direct comments about DSM-IV-TR psychopathology, it yields information on the 11 clinical scales that can assist the doctor in arriving at a psychological diagnosis. These scales provide information about possible alcohol and drug problems, antisocial and borderline personality features, depression, anxiety and anxiety related disorders, mania, paranoia, Schizophrenia and physical complaints. The treatment consideration scores can be helpful in formulating treatment plans and avoiding potential complications. Most importantly for the forensic practitioner, the validity scales measure the person’s attempts to present him or herself in an unrealistically favorable or unfavorable light as well as provide a measure of response consistency and an index of rarity of responses that may reveal a lack of honesty. Since the publication of the test in 1991 there has been a substantial output of research with, as of this writing, 299 articles appearing in PsycINFO, the journal article database maintained by the American Psychological Association. With minimal exceptions, those articles have been generally favorable to the test. By one accounting the PAI is the fourth most used test in psychology. Moreover, forensic psychologists have reacted positively to the PAI with one research article reporting that the PAI has been used in 11% of the cases claiming an emotional injury.

**Pain Drawing Inventory**


One test that has had a limited appearance in my practice is called the Pain Drawing Inventory. Unfortunately, a survey of the PsycINFO database reveals not a single reference to published research on the Pain Drawing Inventory. As such, this procedure or test has absolutely no known validity or reliability with regard to assessing psychopathology.

**Pain Patient Profile (P3)**

The Pain Patient Profile (P3) is a 44-item questionnaire that asks the individual to pick one of three alternatives that best describes their feelings, thoughts and/or behaviors about a variety of issues relating to pain. Examples of items of this type that do not actually appear on the test are, (1) I am usually tense, (2) I have some trouble with tension, and, (3) I have a lot of trouble with tension. There is also a five-item Validity Index that is intended to identify random responding, reading comprehension problems and symptom magnification. Unfortunately, there is no published research demonstrating that either the questionnaire or Validity Index is valid or reliable. In fact, in reviewing the literature on psychological testing, consultation with the PsycINFO database reveals only ten published articles on this instrument. Additionally, there was only one publication dealing with the Validity Index. However, that study indicated that the Validity Index was unable to distinguish between individuals who had a pain disorder and those who were instructed to feign a pain disorder (McGuire & Shores, 2001). Accordingly, it is obvious that this test has no known relationship to psychopathology in a medical legal context.

**Penn Inventory for Posttraumatic Stress Disorder (Penn)**

The Penn Inventory for Posttraumatic Stress Disorder (Penn) is a 26-item self-report measure designed to assess the DSM-IV-TR symptoms of a Posttraumatic Stress Disorder. The individual taking the test selects one statement from a series of four sentences that best describes the frequency, degree or intensity with which their signs and/or symptoms have occurred in the past week. The inventory does not attempt to measure all of the signs and/or
symptoms of a Posttraumatic Stress Disorder and includes questions not related to the DSM-IV-TR criteria, such as self-knowledge. The scores on the Penn vary from 0 to 78 and the published research appears to indicate that the scores are related to the likelihood of an armed services veteran having a PTSD. Unfortunately, a survey of the PsycINFO database system indicates that there is no published research on this test indicating that there are any measures for assessing truthfulness of the test-taker’s responses. Accordingly, the Penn Inventory for Posttraumatic Stress Disorder has no known credibility with regard to providing any information about the possibility of a psychological disorder in a medical-legal context.

**Personal Problems Checklist for Adults**

The Personal Problems Checklist for Adults is simply a list of 208 problems that the authors of the test state that people commonly face. The person taking the test is asked to check each problem they have and to circle those problems that cause them the worst problems. The test-takers are urged to respond to each of the items as “honestly as you can.” The test has no validity scales for assessing the truthfulness of the individual’s answers. Moreover, as is true of all checklists of this nature, the presentation of the items in the context of a medical-legal examination can act as an encouragement to claim problems that do not exist or to exaggerate their severity. In light of the absence of validity scales there are no methods to assess the extent of the individual’s intentional or non-intentional distortion. Moreover, a review of the PsycINFO database system reveals a notable lack of data in the literature indicating that this instrument can assess for psychopathology or measure credibility. Accordingly, it is not reasonable to use the Personal Problems Checklist for Adults in a medical-legal examination.

**Posttraumatic Distress Scale**

One test that has appeared in a number of medical-legal evaluations in the Southern California area is the Posttraumatic Distress Scale. However, a search of the American Psychological Association's PsycINFO database revealed that as of this writing
there was only a single reference to the Posttraumatic Distress Scale. However, that reference is not a journal article but an abstract or summary of a doctoral dissertation (Cason, 2001). Thus, there is not a single published journal article in a refereed journal indicating that the Posttraumatic Distress Scale is a reliable or valid measure for assessing either psychopathology or an individual’s credibility with regard to any presenting complaints in a medical-legal context.

**Quality of Life Inventory**

On a number of occasions I have encountered medical-legal reports in which the doctor stated they have administered the Quality of Life Inventory (QOLI). A search of the PsycINFO database reveals that there have been a number of articles published on the Quality of Life Inventory. In fact, there are different Quality of Life Inventories for different types of populations, such as the Pediatric Quality of Life Inventory and the Multiple Sclerosis Quality of Life Inventory. The basic instrument was developed by Dr. Robert Frisch in 1988 and is a tool that has been used in research and practice to measure an individual's perceived quality of life. When the QOLI Inventory, without any qualifiers like those mentioned above are present, it can be assumed that the version for non-specified adults was used. This version contains 32 items that the person rates on a three-point rating scale for “importance,” and six-point rating scale for “satisfaction.” As such, the QOLI yields both an overall score and a profile of problems and strengths in 16 areas of life such as love, work, health, self-esteem, goals and values, neighborhood and community. Since it was developed and “normed” on a non-clinical population and is used to assess normal individuals to assist them in raising their satisfaction with life, the test has limited applicability in forensic circumstances. More pointedly, this instrument has no known validity or reliability with regard to arriving at a DSM-IV-TR diagnosis in a medical-legal context.

**Raven’s Progressive Matrices**

The Raven’s Progressive Matrices is both a well known and accepted measure of nonverbal reasoning that is especially useful in
assessing individuals who do not speak English. It was intended to be a “culturally fair” test of general cognitive skills. The items consist of a set of 60 items in which each item contains a patterned line drawing from which one part has been removed. The person’s task is to select the piece that has been removed from a set of alternatives. The items vary in difficulty and the test has been given to large numbers of people so that credible statements can be made about an individual’s intellectual ability in comparison to their demographic group. There are no specific tests for truthfulness. However, if a person performs more poorly than would be expected from the rest of the psychological assessment, one could support the conclusion that they were not trying their best. Additionally, since the items vary in difficulty, one could arrive at that conclusion if the person performed more poorly on the easy items than on the more difficult items. Overall, when a culturally unbiased measure is needed, the Raven’s is both a valid and reliable measure of intellectual ability.

**Rey 15-Item Memory Test**

The Rey 15-Item Memory Test is an easily administered instrument that has sometimes been used as a simple screening device to assess attempts to fake memory impairment or amnesia (Rey, 1964). In this test an array of 15 letters, numbers or dots is shown to the individual and they are then asked to reproduce the pattern from memory. The task is very simple as the material presented is repetitive and conforms to an obvious pattern. Because of the simplicity of the task, Dr. Muriel Lezak has recommended that a score of fewer than nine correct out of 15 suggests the person is likely attempting to fake memory impairment (Lezak, 1983). Unfortunately, while this test has seen some clinical use, a large number of studies have demonstrated that the Rey-15 is not a sensitive or useful test in detecting malingering of memory impairment or amnesia (e.g., Schretlen, Brandt, Krafft, & Van Gorp, 1991). Additionally, it should be obvious that the demonstration that the individual may not be attempting to fake a memory impairment does not in any way imply that they might not be attempting to fake any of a myriad of other psychiatric symptoms.
Rorschach Inkblot Test

The well known Rorschach Inkblot Test was devised by Dr. Hermann Rorschach, a psychiatrist, and involves presenting individuals with standardized inkblots and interpreting their statements about their perception of those visual stimuli. Next to the Minnesota Multiphasic Personality Inventory (MMPI) it is the second most used test in psychological evaluations. For most of the Rorschach’s history, the test administrators have interpreted the person’s productions in a subjective fashion. In this regard, many examiners rely on their own subjective clinical judgment in arriving at conclusions concerning the test-taker’s psychological status. However, more recently, Dr. John Exner has developed an objective system for assessing the individual’s inkblot interpretations (Exner, 1993; Exner, 2002). The use of this system allows for objective information to be presented to the court about the meaning of an individual’s productions and the likelihood that they have or have had a psychological disorder. However, there are some data in the literature that indicate that Dr. Exner’s Semantic Computer Interpretation program is susceptible to “faking” in at least some circumstances (e.g., Kahn, Fox, & Rhode, 1988). Accordingly, in the absence a comprehensive program that has shown that there are effective methods to detect attempts to simulate symptoms, it is difficult to accept the Exner system’s conclusions in a medical-legal context.

Rosenzweig Picture Frustration Test

The Rosenzweig Picture Frustration Test is a projective test designed to measure personality characteristics rather than psychopathology. The test involves showing 24 cartoon pictures that each portray two people facing a frustrating situation. Each cartoon contains two “balloons,” one in which the person doing the frustrating has made a comment consistent with what is displayed in the cartoon, such as, “I’m sorry I spilled that coffee all over your new suit.” The person taking the test is asked what they believe the other person would do or say in response to what has occurred. There are two ways of interpreting the results. In the first, the person’s responses are categorized according to the type and frequency of
responses that occur in dealing with the frustrating circumstances. These data are then compared with published norms. In the second, the administrator forms an overall subjective impression of how the person deals with frustration. Unfortunately, regardless of which method is used, the test is subjectively interpreted and has no way of assessing attempts to respond deceptively and therefore cannot be utilized in a medical-legal context.

**Rotter Sentence Completion Test**

The Rotter Sentence Completion Test is one of many different sentence completion tests that all share the same characteristic in that the test-taker is presented with the first portion of a sentence, called a stem, that they are asked to complete in any manner that they deem appropriate. Examples that are not on the test are, “If only I could……..” and “My father…….” In the case of the Rotter, the test-taker is instructed to complete the 49 sentences in a manner that expresses their “real feelings.” One way of handling the person’s responses is to score them on a 7-point scale according to the level of adjustment the test administrator perceives in each completed sentence. Another interpretation method involves the administrator developing an overall impression of the test-taker’s adjustment level. Regardless of the method of interpretation used, the examiner is always in a position of subjectively interpreting the patient’s production. Clearly, there are no known standards or methods for objectively detecting the meaning of the individual’s responses. Moreover, there is no method for detecting deceptive responding that may be found in medical-legal cases. As such, this instrument has no validity or reliability with regard to assessing psychopathology in a forensic setting.

**Rotter Internal-External Locus of Control Test**

The Rotter Internal-External Locus of Control Test is an instrument that has been used to measure an individual’s perception of the locus of control of their life. The test consists of 29 items in which the individual is instructed to pick one of two alternatives. The items are written so that one alternative indicates that the person
perceives their life to be controlled by factors outside of him or herself. The selection of the second alternative indicates that the person perceives their life to be under their own control. The person’s score is determined by adding up the number of questions on which they picked the locus of control being within him or herself and that score is compared to the results obtained by a national sample. Because the test has no validity scales it has no way of testing for truthfulness of responding and, like other questionnaires of this nature, can only be meaningfully interpreted if there are other data indicating that the person has approached the examination in an honest and frank manner.

**Sentence Completion Tests – Generic**

With regard to the sentence completion tests, it should be understood that there are many such projective instruments in which the individual is given the first part of a sentence, called a stem, and asked to complete the sentence in any manner in which they deem appropriate. Some of these tests are published and sold by various entities. Some psychologists conducting examinations apparently write their own. Regardless, the individual administering this test then “interprets” what they feel is the meaning of the individual’s productions. Unfortunately, there are no demonstrably credible standards for interpreting the results of sentence completion tests, resulting in a situation in which this procedure has absolutely no validity or reliability with regard to assessing psychopathology in a medical-legal context.

**Shipley Institute of Living Scale (SILS)**

The Shipley Institute of Living Scale is a widely used measure of general intellectual ability in adults who are known to be neither borderline mentally retarded nor more severely disabled. The test is composed of two subtests: a 40-item Vocabulary Test and a 20-item Abstract Thinking Test, each of which takes ten minutes to administer. This test is known to be a valid and reliable instrument and has been shown to exhibit high positive correlations with more lengthy and time-consuming instruments such as the Wechsler Adult
Intelligence Scale-III (WAIS-III). As such, it is a more efficient instrument to use as part of a psychological test battery where a general assessment of overall intellectual functioning is needed, but the more detailed information provided by the Wechsler Adult Intelligence Scale-III is not necessary.

**Simplified Rathus Assertiveness Schedule (SRAS)**

The Simplified Rathus Assertiveness Schedule (SRAS) is a test that measures an individual’s social skills and functional social concepts. It provides a score that indicates how assertive the individual is in comparison to other people. It is also a measure of the individual’s self-perception. The test consists of 30 declarative statements that can be applied to anyone taking the test. In this regard, an example of an item that could be, but is not, on the test reads as follows, “There are times when I tell people exactly what I think.” The person completing the test responds to each item by stating on a 7-point rating scale how much each of the behaviors, thoughts or feelings described in the items is like them. The person’s score is determined by adding up the number of questions on which they picked the assertive response and that score is compared to the results obtained by a national sample. The test has no way of testing for truthfulness and like other questionnaires of this nature can only be meaningfully interpreted if there are other data indicating that the person has approached the examination in an honest and frank manner.

**State-Trait Anxiety Inventory (STAI)**

The State-Trait Anxiety Inventory (STAI) was designed to identify what the author conceived of as two different forms of anxiety, State Anxiety and Trait Anxiety. State Anxiety is the individual’s level of anxiety as it exists at any point in time. Trait Anxiety is the relatively stable level of anxiety that an individual has at most times. Quite simply, State Anxiety is how the individual feels “right now,” and Trait Anxiety is how the person “generally” feels. In both cases anxiety is assumed to be the subjective feelings of tension, apprehension, nervousness, worry and activation of the
autonomic nervous system in the form of such signs as increased muscle tension, increased blood pressure, shortness of breath, heart palpitations, and a rapid heart rate. The STAI comes in two forms. Form Y-1 measures State Anxiety and Form Y-2 measures Trait Anxiety. Examples that are not actually part of the test read as follows, “I feel good,” a measure of State Anxiety, and “I have self-esteem,” a measure of Trait Anxiety. The individuals taking the test rate themselves on a four-point scale according to how well they believe that the items describe them across time. The ratings vary from “Almost Always” to “Almost Never.” Twenty items pertain to how the individual generally feels, Trait Anxiety, and twenty items pertain to how they feel at the time of the testing, State Anxiety. Unfortunately, an inspection of the test indicates that the test items are highly transparent and there is no method for detecting individuals who are not being truthful (Spielberger, 1983). Therefore, in a medical-legal context the STAI is not an appropriate instrument to use, as it cannot provide any valid information concerning the examinee’s psychological status.

Subjective Profile of Personal Effectiveness

One “test” that has shown up on a number of medical-legal evaluations from psychologists and psychiatrists in the Southern California area is the Subjective Profile of Personal Effectiveness. However, attempts to obtain data about this instrument have been fruitless. In particular, a review of the literature on psychological testing conducted through PsycINFO, the database system maintained by the American Psychological Association, revealed no published research articles on the Subjective Profile of Personal Effectiveness. Accordingly, this test has no known validity or reliability and, therefore, no known relationship to psychopathology in a medical-legal context.

Suicide Probability Scale

This test is composed of 36 items that describe particular feelings and behaviors. Questions similar to those appearing on this test are, “I think of killing myself,” and, “I often feel lonely and alone.”
The person taking the test responds to each of the items using a four-point rating scale. The person’s choices are: (1) None or a little of the time, (2) Some of the time, (3) a Good part of the time, and, (4) Most or all of the time. Unfortunately, the test has no method for determining the truthfulness of the person’s responses. There is also no objective, valid or reliable method for obtaining a probability of suicide. The test administrator is urged by the testing manual to compare the person’s scores with their clinical presentation to arrive at an impression of the likelihood of suicide (Cull & Gill, 1988). As such, the test is a subjective instrument not capable of providing any objective or credible information about the probability that any given individual will hurt him or herself. In a medical-legal context the test has no known validity or reliability for assessing psychopathology.

**Symbol Digit Modalities Test**

[See the Digit Symbol Modalities Test]

**Symptom Checklist-90-Revised (SCL-90-R)**

The Symptom Checklist-90-Revised (SCL-90-R) is one of many available symptom checklists in which an individual is provided with a list of possible symptoms and given the opportunity to endorse or deny those complaints. In the case of the SCL-90-R the person is presented with 90 items that are possible symptoms or complaints and specifically asked, how much they are distressed by such symptoms as headaches, suicidal thoughts and feelings of worthlessness. The individual taking the test rates each of the 90 items on a five-point scale, where the points on the scale are defined as, “Not at all,” “A little bit,” “Moderately,” “Quite a bit,” and “Extremely.” Unfortunately, the SCL-90-R has no method for detecting individuals who are attempting to report complaints that do not exist. Additionally, the use of such a checklist in a medical-legal context is unacceptable, as the list itself can be an encouragement to claim symptoms that do not exist. Accordingly, in the context of a medical-legal examination, the SCL-90-R cannot provide any information about a claimant’s psychiatric status at any point in time.
Symptom Checklists - Generic Forms

Symptom checklists have been used by many psychologists to obtain a relatively large amount of information about a patient’s complaints in a relatively short period of time. There are many different symptom checklists, and some psychologists have taken it upon themselves to create their own. A symptom checklist, as the name clearly implies, is simply a list of symptoms or complaints that the individual can either endorse or deny. Unfortunately, there are no known symptoms checklists that have any means of assessing truthfulness. As such, they have no known validity or reliability nor any utility in a medical-legal evaluation. In fact, the use of a symptom checklist in such an examination can be an inducement to claim symptoms or complaints that do not exist. Thus, the use of such a checklist prior to an interview seriously questions the complaints made to the doctor during the history taking.

Taylor-Johnson Temperament Analysis Scale (T-JTA)

The Taylor-Johnson Temperament Analysis Scale (T-JTA) was designed to measure what are conceived of as nine dimensions or traits of personality. The testing manual for this instrument reports that the dimensions were selected because they were “important components of personal adjustment” (Taylor & Morrison, 1984). Three of the nine dimensions or traits listed in the manual are “Nervous vs. Composed,” “Depressive vs. Lighthearted,” and “Dominant vs. Submissive.” The manual also specifies that this instrument was developed for use by counselors to help individuals identify problems in their lives. The test itself requires that the individual rate him or herself on 180 items. A reading of these items indicates that they are highly transparent with regard to what they are intended to measure. As such, they do not lend themselves to use in forensic examinations. Moreover, it is specifically stated on page 6 of the testing manual that the T-JTA was not “designed to diagnose or identify psychiatric conditions or problems.” On page 15 of that manual the authors also noted that “Important decisions should not
be made on the basis of” the test results without “confirmation of these results by other means.” Accordingly, the T-JTA’s use in a medical-legal examination is clearly inappropriate, as this instrument cannot provide information about psychopathology.

**Test of Memory Malingering (TOMM)**

The Test of Memory Malingering (TOMM) is an effective device for differentiating between individuals who have a memory impairment and those who are attempting to fake a memory dysfunction (Tombaugh, 1997). A person taking the TOMM is shown 50 simple line drawings for three seconds each. Thereafter, they are shown 50 sets of two simple line drawings each, with one of the drawings having been previously seen and the other drawing having never been seen. The test-taker is then asked to select the drawing they had previously seen. Individuals who are attempting to mangle assume the test is difficult, and perform much more poorly than non-malingering individuals who may have actual memory impairments. This conclusion is supported by research that has shown that patients with known cognitive impairment, aphasia, and/or a traumatic brain injury obtain almost perfect scores, whereas malingerers perform substantially poorer. In the context of a medical-legal examination, a poor performance indicates the person is attempting to simulate an impairment in memory, although a high level of performance does not necessarily indicate that they are not attempting to simulate some non-memory dysfunction. Clearly, the TOMM is only capable of assessing the malingering of memory impairment, as it was intended to do, and is not capable of assessing faking of other psychological functions.

**Thematic Apperception Test**

The Thematic Apperception Test is a projective test that requires the examinee to write a story, or provide a description, for each of a series of cards. There are 30 cards containing vague or ambiguous black and white pictures and a single blank card. For each individual who is given the test the examiner selects 20 cards and presents 10 on each of two different days. The person taking the
test is asked to make up a story about each picture, describing what led up to the event depicted, what was happening at the moment, what the characters were thinking and feeling, and what was going to be the outcome. This test is supposed to reveal an individual’s perception of their interpersonal relationships. Although there have been some normative data published, most clinicians interpret the test’s results according to their own personal experiences, subjectively interpreting the meaning of the individual’s productions. As is true of most projective instruments, there is no way of determining if the administrator’s conclusions have any credibility or validity with regard to providing information about the test-taker’s psychiatric status, or the possibility that they have or have had a psychological disorder. Clearly, the TAT has been criticized for its lack of a standardized method of administration as well as the lack of standard norms for interpretation. Accordingly, the TAT is useless in providing objective data in a medical-legal context.

**Trail Making Test**

The Trail Making Test is a neuropsychological test used to assess organic brain impairment. More specifically, it is an instrument that measures speed of visual search, attention, mental flexibility and motor function. The test requires that the individual use a pencil to connect 25 encircled numbers, or 25 encircled numbers and letters, which are randomly arranged on a page. The person’s score is the time it takes to complete the tasks. While the test is known to be useful in detecting neuropsychological problems by measuring speed, attention, mental flexibility and motor behavior, there are no data in the literature indicating that it is either valid or reliable with regard to assessing psychopathology that is not associated with a brain impairment.

**Trauma Symptom Inventory (TSI)**

The Trauma Symptom Inventory (TSI) is a 100-item self-report test that is designed to assess a variety of symptoms or complaints associated with a history of having experienced such traumas as rape, spousal abuse, physical assault, combat, major accidents,
disasters, and the lasting effects of childhood abuse. The person taking the test rates each complaint according to how often it has occurred in the previous six months by using a four-point scale that varies from “never” (0) to “often” (3). The test has ten clinical scales used to provide information on such dimensions as depression, anxiety, anger and irritability. The Trauma Symptom Inventory also has three validity scales that are useful in assessing the underreporting and over-reporting of complaints, as well as response consistency. As noted by the publisher, the TSI does not produce a DSM-IV-TR diagnosis, but provides information about the complaints associated with traumatic experiences. An inspection of PsycINFO, the American Psychological Association database, reveals that as of this writing the TSI has been the subject of 106 published research articles that appear to speak favorably about the test’s ability to produce credible information about the symptoms of traumatic psychological disorders in a medical-legal context.

**Wahler Physical Symptoms Inventory**

The Wahler Physical Symptoms Inventory is a questionnaire requiring the patient to state how often they experience a set of 42 physical symptoms such as “headaches, difficulty sleeping and backaches.” For each such physical problem, the person rates him or herself on a six-point frequency scale that varies from “Almost Never” to “Nearly Every Day.” Unfortunately, an inspection of the testing manual for this instrument indicates that there are no validity scales for this questionnaire (Wahler, 1983). Accordingly, there is absolutely no method for detecting individuals who are endorsing complaints that do not exist. Moreover, the use of this type of a questionnaire in a medical-legal context is inappropriate as the presentation of the items can be an encouragement to claim symptoms or complaints that do not exist.

**Wechsler Adult Intelligence Scale-III (WAIS-III)**

The Wechsler Adult Intelligence Scale-III (WAIS-III) or, as it is sometimes called, simply the “Wechsler” or the “WAIS” is the most recent revision of a long line of tests of general intelligence dating
back to the 1939 publication of the Wechsler-Bellevue test, that was itself an adaptation of a test developed and used by the United States Army in the 1920’s. General intelligence is described as an I.Q. score or an Intelligence Quotient. I.Q. is calculated by dividing mental age, as defined by the test, by chronological age and multiplying by 100. Thus, if you are 30 years old and your test results are at the average for a 30-year-old, that is your mental age is 30, then your I.Q. is 100, the average or mean of the general population.

Overall, general intelligence was conceived of by the originator of the Wechsler, Dr. David Wechsler, as the ability to think rationally and act purposefully and effectively (Wechsler, 1939). In its current form, the WAIS-III provides three basic measures: a measure of verbal ability (a Verbal I.Q.), a measure of performance ability (a Performance I.Q.) and an estimate of the person’s overall or general intelligence or what is referred to as the Full Scale I.Q. (Wechsler, 1997). A person’s Full Scale I.Q. is what most people refer to when they talk about an individual’s I.Q. The WAIS is appropriate for use in individuals 16 years old or older. For younger individuals, Dr. Wechsler has devised the Wechsler Intelligence Scale for Children (WISC).

On the WAIS-III there are 7 subtests that measure verbal ability and 7 subtests that measure performance ability. The verbal ability subtests measure comprehension and memory. The performance ability subtests measure perceptual organization and processing speed. The scores or performances on these 14 subtests are combined to provide an overall measure of I.Q., called the Full Scale I.Q. Norms have been developed for a wide variety of populations. The calculated I.Q. score compensates for performance decrements that tend to occur as people age, so that the average I.Q. is 100 for all age groups. Approximately two thirds of the population falls between the scores of 85 and 115. It takes about one and one-half to two hours to administer and score the WAIS-III.

Various types of psychopathology can adversely affect the WAIS-III scores, but usually there is no prior testing or baseline for comparison that would allow for an assessment of any possible decrements as a result of psychopathology. As such, the WAIS-III can only provide extremely rough estimates of any such possible
decrements in I.Q. as a result of psychopathology. Under these circumstances, the psychologist is forced to compare the person’s current I.Q. with a history of their prior behaviors in order to arrive at some conclusions about any adverse affects due to the causes of their litigation. With regard to the one and one-half to two hours administration time, there are many other instruments that provide valid measures of general intelligence in a much shorter period of time. Employing such an instrument is a more economical use of the psychologist’s resources in generating a valid and reliable estimate of general intelligence and the likelihood of a psychological injury.

**Wechsler Memory Scale-Third Edition (WMS-III)**

The Wechsler Memory Scale-Third Edition (WMS-III) is the updated version of the Wechsler Memory Scale, Revised. The test takes approximately 45 minutes to administer individually and measures different forms of immediate and delayed auditory and visual memory. The test is sensitive to memory impairments and is frequently used in neuropsychological test batteries to assess dementia and other memory deficits associated with injuries, aging and neurological disorders. It is also used in general psychological test batteries where an individual’s memory functions may be at issue. However, unless there is some reason to suspect a psychological disorder that is characterized by memory impairment, there is little reason to use the WMS-III in a medical-legal psychological evaluation.

**West Haven-Yale Multidimensional Pain Inventory (WHYMPI)**

[see the Multidimensional Pain Inventory (MPI)]

**Wonderlic Personnel Test (WPT)**

The Wonderlic Personnel Test (WPT) is a highly valid and reliable measure of cognitive performance that contains 50 objective problems of a verbal, spatial and arithmetic nature. The individual taking the test is given 12 minutes to solve as many problems as they
can. Almost no one can complete all 50 items correctly. A variety of objective research has demonstrated that the test is a valid and reliable measure of adult intelligence. The result of the test is expressed as an Intelligence Quotient (I.Q.). The arithmetical mean or average I.Q. for the general population is 100. Approximately two-thirds of the population receives a score between 85 and 115. The WPT is known to correlate highly positively with the gold standard in the area of intelligence testing, the WAIS-III (Dodrill & Warner, 1988). The principal advantage of the WPT is the speed with which it can measure intelligence. The principal advantage of the WAIS-III is that it can yield a good deal more information than the WPT. In the context of a claim of a psychological injury, where the major question is the individual’s overall level of cognitive performance or intelligence, the WPT is an economical choice.

**Word Memory Test**

The Word Memory Test is a neuropsychological instrument that was created by Dr. Paul Green in 1995 for assessing memory and distinguishing between attempts to simulate memory problems and true memory difficulties caused by a brain injury. Outside of the realm of assessing for organic brain impairment, the Word Memory Test is not known for its ability to measure psychopathology, although results from this test can be used to provide information about the existence of memory problems and indicate if the test-taker was attempting to simulate memory dysfunction.

**Zung Depression Scale**

The Zung Depression Scale is a self-report inventory that asks the person to rate him or herself on 20 different psychological and physical symptoms of depression such as crying spells, a loss of weight, trouble sleeping at night and having difficulty enjoying sexual relations. Each of the items is rated on a four-point scale according to how frequently each of the symptoms occurs. The specific rating choices are, “A little of the time,” “Some of the time,” “Good part of the time” and “Most of the time.” One of the strongest criticisms of the Zung Depression Scale is that there is no provision for the test-
taker to report “Never,” or to deny the occurrence of any of the complaints or symptoms. Regardless, a total score is obtained and the author of the test reports that, “most people with depression score between 50 and 69.” As with many other self-report inventories of this nature a reading of the literature reveals that the Zung Depression Scale has no validity scales for assessing the individual’s test-taking attitudes, or the credibility of their responses (Zung, 1965). Accordingly, the Zung Depression Scale has no validity or reliability with regard to assessing psychopathology in a medical-legal context and is not capable of providing any information to indicate if any given individual has had a psychological injury as a result of their experiences.

II. Selecting a Test Battery

The above discussion clearly implies that there are a limited number of psychological tests that can be relied upon to provide valid and reliable objective data for drawing conclusions in the context of a medical-legal examination. Essentially, these tests fall into three categories, depending on whether they measure (a) organicity, or the likelihood of brain damage, (b) cognitive abilities or general intelligence, or (c) psychopathology and personality.

When it comes to assessing organicity, the most useful tests are the Bender-Gestalt Test, the Hooper Visual Organization Test and to a lesser extent the Graham-Kendal Memory for Designs Test. In the area of measuring cognitive abilities, the gold standard is the Wechsler Adult Intelligence Scale-III (WAIS-III). However, as noted above, this test takes about one and one-half to two hours to administer and score, which may be too costly in time and money if one is simply interested in an overall measure of cognition. Under these circumstances the Raven’s Progressive Matrices, the Shipley Institute of Living Scale and the Wonderlic Personnel Test provide overall measures of intelligence in a much shorter period of time, although they do not provide the rich amount of information provided by the WAIS-III. Finally, in the area of psychopathology and personality, the gold standard is the Minnesota Multiphasic Personality Inventory (MMPI). In this regard, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) has not lived up to the
standards established by the MMPI. Moreover, the soon to be released Minnesota Multiphasic Personality Inventory-2-Restructured Form is an unknown quantity, and will remain so for probably many years until independent research establishing its usefulness is completed. The Millon Clinical Multiaxial Inventory-III (MCMI-III) is a good measure of psychopathology if there is already hard evidence indicating that the individual has a psychological disorder. Finally, the Cattell Sixteen Personality Factor Test (16PF) and the more recently developed Personality Assessment Inventory (PAI) both have validity scales for assessing credibility and are known to provide valid and reliable information about personality and psychopathology. In short, although there are thousands of available tests, there are relatively few that meet the standards of providing reliable, credible and objective data concerning psychopathology.
Chapter 8

The Review of the General Medical Records

As noted earlier, the patient’s medical records are one of the five sources of data used by the reporting doctor to determine the patient’s psychological status and to decide if the patient has had a psychological injury. In conducting, as well as discussing, a psychological examination, it is convenient to divide the medical records into those dealing with psychological issues and those records that may be available from practitioners in other medical disciplines such as orthopedics, neurology, chiropractic, physical therapy, and radiology. Included in the non-psychological records are legal records, such as depositions and other court records, employment records, educational records, and, on occasions, records of professional investigators, including sub rosa video recordings.

While very often the above noted non-psychological records have relatively little relevance to the outcome of a psychological evaluation, there are many cases in which they provide very important data. For example, in a case where the patient is a poor historian, due to no fault of their own, comments made by an orthopedist about the patient’s psychological status may lead me into a line of interviewing that might uncover some psychological complaints that the patient simply was not comfortable revealing, which point to their having suffered a psychological injury that might otherwise go undetected. Similarly, those same orthopedic records could reveal data damaging to the patient’s claim.

Typically, the medical records are reviewed prior to examining the patient so that I will have a database that will allow me to form an impression of the patient prior to the testing and the interview. Clearly, as discussed above in reference to the patient whose orthopedic records led to finding out about psychological complaints they were not comfortable revealing, reviewing the records prior to interviewing the patient will often provide some reasonably good ideas about where to take the interview. Essentially, as a result of reading the records, I am able to form a variety of hypotheses or ideas about the patient that can then be evaluated and, if necessary, changed as a result of the testing and interviewing.
Having put the testing, interviewing and any collateral sources of information in perspective with the medical records, it is necessary to provide the reader of the report with a discussion of the relevant information found in those records. Essentially, I want to tell the reader of the report what the medical records reveal and how those data are relevant to and consistent with my conclusions about the patient’s psychological status. In many cases the medical records will not have anything relevant to state about factors or variables that have affected the patient’s psychological status. Nevertheless, I believe it is important to demonstrate to the reader of the report that I have reviewed the medical records and described what they contain. If for no other reason, this is done to show that there is information in the medical records supporting whatever conclusion I have arrived at or, at the very least, no data contradicting my conclusions. Writing my report in this manner is consistent with my firm belief that I must support all of my conclusions with data. It is also consistent with my imaginary cross-examining attorney asking me to explain, support and defend everything I say.

I. General Medical Records from Treating Physicians

General medical treating records are those produced by practitioners who have evaluated and/or treated the patient outside of the context of their litigation or claim. Typically these are records from physicians who have treated the patient for a variety of reasons. They may include records from family practitioners, orthopedists, dentists, chiropractors and acupuncturists. There also may be records from an HMO, such as Kaiser Permanente, where the individual has been seen by many doctors who have different specialties. In the case of records produced by practitioners outside of psychology and psychiatry, I most often make minimal comments that simply summarize what the doctor said, offering statements of the relevance, if any, to the results of my evaluation. Typically it is enough to report on the doctor’s name, their specialty if known, the date of contact or the date of the report, the doctor’s diagnosis, statements of their belief about the person’s status in their medical area if any, and the treatment being administered. Of course, I will want to comment on any information that is consistent or inconsistent with the data I obtained during my examination. For example, I have
had a patient tell me that she had never had any serious illnesses or physical conditions but when I read her records I found that she was under treatment for breast cancer. This discrepancy is highly relevant to note since it speaks directly to the patient’s credibility as well as to their possible psychological status.

Finally, when there are a series of medical records from the same practitioner, or different practitioners, which fall under the same heading, it is best to deal with those records in chronological order. In fact, by putting the records in chronological order before I read them I can form an impression of what has occurred in the patient’s life in the order in which it has occurred.

II. General Medical Records - Medical-Legal Reports

Most of the time, the non-psychological medical records I review consist of medical-legal reports from other practitioners. Frequently, these are from orthopedists, internists, radiologists, and neurologists. As I am not an expert in any of these areas, I cannot provide any critical commentaries concerning the contents of these documents. I leave that up to practitioners in those areas. However, what I must do is to indicate that I have read the documents and generally understand what the physician is stating and what the patient has reportedly experienced. Typically it is enough to report on the doctor’s name and specialty, the date of the report, the patient’s complaints, the doctor’s diagnosis, the doctor’s statements about the patient’s disability status, the doctor’s prognosis and the treatment being administered. As noted above, it is inappropriate for me to comment on the credibility of a doctor’s report in any area but psychology or psychiatry. However, I typically feel compelled to comment on the patient’s credibility if I find out that the patient gave the orthopedist a very different history than the history given when the patient was in my office. For example, I have seen cases where an orthopedist has stated, “This has been Ms. Brown’s fourth injury in an automobile accident that required medical treatment.” Yet when Ms. Brown was in my office she said she had never had any other accidents that required medical treatment. Of course, since this speaks directly to the credibility of the patient it is crucial to point this out in the review of the medical records.
There is a single exception with regard to commenting on the credibility of a report written by a doctor in a specialty other than psychology or psychiatry. This occurs when the doctor attempts to make statements about the patient’s psychological status. In this regard, an orthopedic surgeon is no more qualified to provide a psychological opinion than a psychologist is qualified to provide an orthopedic opinion. When I find a physician in a specialty other than psychology or psychiatry making comments about the patient’s psychological status, I feel it is absolutely essential to comment on the credibility of that opinion by pointing out that the doctor is not qualified to make those comments and there is no support for any such conclusions. In these cases I might state something like, “With regard to Dr. Smith’s comment about Ms. Brown’s ‘psychological symptoms,’ it should be noted that there is no indication that Dr. Smith took a complete psychological history, administered a Mental Status Examination or gave Ms. Brown any psychological tests. There is also nothing in Dr. Smith’s report to indicate that he arrived at a DSM-IV-TR diagnosis or if he is a trained or qualified examiner in either psychology or psychiatry. Accordingly, his comments regarding Ms. Brown’s psychological status have no known validity.”

III. Deposition Transcripts

In addition to reviewing records from physicians and other medical practitioners, I am often called upon to review deposition transcripts. Most of the depositions I read are those given by the patient. When asked to do so I try to read them with two thoughts in mind. First, is there any evidence of a psychological disorder or a psychological injury? Obviously, if the patient is claiming to have a psychological disorder and a psychological disability and my reading of the deposition transcript reveals no such evidence, it is relevant to note that conclusion. Second, I look to see if the information presented in the deposition testimony is consistent with the information I obtained during the course of my examination. If the patient presents a different historical accounting of him or herself during the deposition, as compared to during my examination, this speaks directly to their credibility. Clearly, it is relevant to note these findings in my report.
IV. Advice for Attorneys Taking Depositions

Unfortunately, it is a very rare deposition that provides evidence addressing the issue of a psychological disorder or a psychological injury. Most frequently the attorneys taking the deposition do not ask the right questions to obtain sufficient history to provide insight into the patient’s psychological status. Probably the principle reason for this is that attorneys simply do not know what to ask. Most typically, when a patient has alleged a psychological injury the attorney will ask some cursory questions about the nature of their symptoms and some of the “where’s, what’s and who’s” of treatment. Nevertheless, the extent of the questions and the breadth of the answers are invariably insufficient to provide much relevant data. For example, in answering a question about their symptoms, I have read patient testimony that indicates that they complained about depression but I have yet to see an attorney ask the patient, “Ms. Brown, people often mean different things when they say, ‘I’m depressed.’ When you say you are depressed can you tell me what you mean by that?”

As I noted in the beginning of this book, one of the reasons that I am writing this is to provide attorneys with information that will make them more effective. In this regard, I would urge attorneys to ask more questions of the person they are deposing that are similar to the types of questions I ask during my evaluations. Accordingly, not only should they ask the person to describe in detail their current symptoms or complaints, but they should also ask how often they have those complaints, how strong they are, how long they last when they get them, and when they began. Essentially, they should obtain information about their symptom’s frequency, intensity, duration and onset. For heuristic purposes I recommend simply recalling the word “FIDO”, which stands for frequency, intensity, duration and onset.

One question that I feel compelled to address is what appears to me to be a difference in the interest of plaintiff or applicant attorneys and defense attorneys in uncovering information about the claimant. Based entirely on experience, I have come to the conclusion that defense attorneys seem happiest when they are discovering as much information as possible. On the other hand, it seems to me that the claimants’ attorneys seem happiest when they can present their case as they see it, and prevent what appears to
them to be irrelevant material from being uncovered. Thus, it seems that defense attorneys are likely to ask more pointed questions in a deposition than attorneys for the claimant. Perhaps I have had too much experience working on the side of the defense and not enough working on the side of the claimant, but I believe that the more information is gathered, the more accurate a picture we have of the patient and the more likely justice is to be served.

On relatively rare occasions I may be sent depositions from other parties to the litigation. Typically, these are depositions of doctors. If the doctor giving the deposition is not a mental health professional, I simply summarize the contents since I am not qualified to comment on their professional opinion. However, if they provide non-technical testimony, say, concerning the patient’s history or what the patient told them they had experienced, I can provide comments along the lines of whether or not that information is consistent or inconsistent with what the patient told me during my examination. Overall, consistency is a major consideration in developing an accurate portrayal of the patient. If no such historical information is found, I simply state that fact. If inconsistent data are found I point out the inconsistencies and comment on the meaning of that information, unless it is relatively trivial.

V. Personnel Records

Very often, especially in workers’ compensation cases, I am sent the personnel records from the employer where the patient was reportedly injured. As I see it, my job is to read these records and point out any relevant data they contain. Included in the records I receive are such things as: performance reviews, letters of commendation, write-ups of poor work performance, time sheets, records of promotions, records of demotions, job actions, employment applications, inter-office correspondences about work issues that may be relevant to the litigation, IRS forms, and payroll data. In reviewing these records I cite any documents that allow me to provide the reader of my report with a picture of what the records show. If they indicate that the patient had a high level of work performance, received multiple promotions and a variety of commendations, I cite the specific records that led to that conclusion.
I also report on how the information in those documents is consistent or inconsistent with the data I obtained during my examination, the remainder of the medical records and my conclusions. As before, I am always looking towards forming a carefully drawn and internally consistent view of the patient.

VI. Investigative Reports

With few exceptions, insurance companies do not take an injured person’s history and complaints at face value. Instead, they go out and obtain their own data about the accident and patient. In addition to getting reports from doctors, this information is sometimes obtained by private investigators. Generally, with regard to a psychological claim, the information they gather attempts to answer three questions. First, what happened to produce the reported injury? Second, what other factors of a psychologically aversive or positive nature are in the person’s background? Third, what is the person now doing?

With regard to the first question, the investigator may go to the individual’s place of employment and interview people. They may interview people who witnessed the injury, if there was one specific incident, such as an automobile accident. If there was a continuous injury, say many occurrences that added up to a cumulative injury, such as often happens in a sexual harassment claim, they will also interview people who have relevant information about those occurrences. The investigator may also interview people who have no connection to the accident at all, say next door neighbors, just to get background information on the claimant, including their possible reactions to the injury and their current behaviors. They then write a report on their findings. In any given investigation there may be interviews with two to ten people. Most usually it is just three or four.

In reviewing those reports I look for any data that is relevant to the patient’s claim of a psychological injury. Overall, the most important factor is the consistency between what the patient told me during the interview and what the investigator found. If everyone interviewed saw something entirely different than what the patient reported, this must be pointed out since it directly addresses the
issue of the patient’s credibility. If the information found in the report is consistent with what I obtained in the interview, this also must be pointed out. Of course, any such inconsistency might be due to the person who was interviewed and not the patient. As Dr. Elizabeth Loftus has pointed out over many years of a highly productive career, the lack of credibility of eyewitness testimony is well known (Loftus, 1996; Loftus & Ketcham, 1991). Accordingly, it is not possible to draw any firm conclusions from one set of data such as the reports of what investigators have found that witnesses have said, especially since those witnesses were not under oath. Nevertheless, such data are useful in constructing an overall picture that must be obtained to get the best possible conclusions concerning the patient and their claim.

In attempting to determine what other factors of a psychological nature are in the person’s background, investigators look into a variety of records that may impact the person’s psychological status. For the most part, they look into public records for evidence of such occurrences as house foreclosures, acrimonious divorces, arrests and incarcerations of the claimant and/or family members, the patient’s participation as a plaintiff and/or a defendants in one or more civil litigations, prior injury claims, tax problems, automobile repossessions, credit problems, etc. All of the above are clearly records of what most mental health professionals consider to be psychologically aversive events. In contrast, while there are some positive things to be found in public records, such as the payoffs of mortgages, good credit ratings, and the successful completion of military service, there are no public records of such things as happy marriages and pride taken at a child’s college graduation. Nevertheless, whatever “negative” data are available may be relevant to the claim of an injury since those data may reveal something that could have produced the alleged injury. It is also possible that the data may reveal something that aggravated either a psychological disorder produced by the accident/injury or a pre-existing underlying disorder. Similarly, whatever “positive” data can be found may also be relevant in demonstrating that there were no pre-existing factors affecting the person’s psychological status in a negative manner, should one find a current or resolved psychological disorder.
With regard to the third question, the investigator often goes into the field and talks to people about the patient’s current activities or obtains sub rosa video surveillance images of the individual. This is typically done when the insurance company suspects that the individual is claiming significantly more disability than is likely to be present. When the video images show a major discrepancy between the patient’s complaints and their behavior this does not bode well for the outcome of their lawsuit. Additionally, in an effort to keep perspective on the nature of sub rosa investigations, one must consider how many of them have shown disability but never make it to the court since they are consistent with the person’s claimed injury.

VII. Job Descriptions or Job Analyses

For work related injuries, as well as non-work related injuries, the person’s ability to do their normal and customary job often becomes an issue in their litigation. In order to appropriately draw conclusions about this ability, the investigation report is often helpful. From my perspective it is also helpful to become aware of the patient’s specific job duties. Especially in work related injuries this awareness is facilitated by reviewing the patient’s Job Description that is provided by their employer. In most cases the job described is consistent with what the employee said their job was during the course of my evaluation. At that point I simply have to draw some conclusion about what I believe is the patient’s psychological ability to do their job.
Chapter 9

The Review of Psychological and Psychiatric Records

As noted on multiple prior occasions, a patient’s medical records are one of the five sources of information used in arriving at conclusions about their psychiatric status. Within the medical records the documents that are most relevant to any litigation alleging a psychological injury are the comprehensive psychological and psychiatric evaluative reports. This section in my reports is also one of the most important. In this section, my job is to analyze reports from psychiatrists and other psychologists and determine if they are credible with regard to their diagnoses and conclusions about the patient’s psychological status and the likelihood that they have had a psychological injury as a result of their experiences. If I find those reports to be lacking in credibility, and the data I present in my report are credible, there are significant consequences to the litigation.

Having come from an academic background that is fundamentally very scientific and precise in data collection, analysis and most importantly in the interpretation of results, I have found that my colleagues who have not had that training and practice often allow substantial flaws to find their way into their reports and testimony. When this occurs I frequently find myself saying about their reports that they are “substantially flawed, grossly lacking in credibility and not capable of proving or disproving a disputed medical fact.” When I can back that statement up with supporting data it rightly results in very little weight being given to the other doctors’ reports in court.

In the above paragraph the word “substantially” is quite important since it is a particularly meaningful term to the attorneys and the court. However, there is no agreed upon definition of substantial as it applies to psychological reports. Nevertheless, there are multiple flaws that can be considered substantial. For example, a report is substantially flawed when there is a major discrepancy between the DSM-IV-TR definition of the disorder diagnosed by the physician and the doctor’s data. Similarly, if the doctor has made a demonstrably major error in scoring or interpreting the test data, this is also a substantial flaw. Additionally, a substantial flaw is said to be present when there is an inadequate, incorrect or incomplete history
or the doctor fails to conduct a complete Mental Status Examination. In a later section I will discuss at length some of the most grievous errors found in psychological reports. However, first I would like to describe what a comprehensive review of a psychological report should contain.

I. The Eight-Paragraph Review of Psychological and Psychiatric Reports

A comprehensive and thorough review of a psychological report should contain a relatively standard set of data for reviewing, analyzing and drawing conclusions about the validity of a psychological or psychiatric report. When the doctor has diagnosed a single psychological disorder, my review breaks down into eight basic paragraphs. In cases where the doctor has diagnosed more than one disorder, each of the disorders must be dealt with separately and therefore there is typically a more extensive discussion. However, for our purposes it will suffice to consider the simple case of the doctor having specified just one disorder. Additionally, for purposes of discussion I will assume that the doctor has diagnosed a disorder.

Before discussing cases where the doctor has diagnosed one or more disorders, it is necessary to consider the case in which the doctor has found no evidence of a disorder but has concluded that the patient is normal. In this case the doctor’s report and the manner in which it is evaluated is identical with a case in which the doctor has diagnosed at least one disorder. Essentially, the same basic paragraphs, with minor modifications, are used to support the doctor’s conclusions that the patient did not have a disorder at the time of their examination and that if they had a disorder in the past, there is evidence indicating that the disorder is no longer present.

Having now seen that whether or not the doctor has diagnosed a disorder, multiple disorders, or no disorder at all, the eight paragraphs found in a review of that doctor’s psychological or psychiatric report are given below:
1. **Paragraph One: An Overview of the Report**

The first paragraph simply provides an overall review of the doctor’s report, giving the doctor’s full name and specialty, the date of the report, any and all of the DSM-IV-TR diagnoses, the doctor’s statement about the patient’s psychological disability status at the time of their report as well as in the past, the doctor’s statement about the cause of the patient’s disorder and/or injury, the doctor’s statement about the patient’s need for treatment, and a sentence or two summarizing my conclusions about the doctor’s report. This brief statement alerts the reader as to what to expect in the coming discussion and can be used as a reference point in reading my report. An example of such a paragraph appears below. Of course, all of the names have been changed. As an aside, please note that in all of the information cited I provide page numbers so that anyone reading my report can easily consult the document I am reviewing and find the information I have presented.

On September 12, 2005, Dr. Maude Magnum, a psychiatrist, submitted a report of her evaluation of Ms. Miller. On page 16 of that report, Dr. Magnum diagnosed a Major Depressive Disorder (296.3). On page 20, Dr. Magnum stated, “Between June 2005 and the
current time, Ms. Miller has been totally temporarily disabled for Workers’ Compensation rating purposes.” On page 23, she stated that all of Ms. Miller’s “work-disabling psychiatric symptoms are due to her work at the Johnson Corporation.” On pages 20 and 21, Dr. Magnum stated that Ms. Miller needed psychiatric treatment. She went on to report that she believed that she needed approximately six months of psychotherapy and psychotropic medication. Overall, an examination of Dr. Magnum’s report indicates that it is substantially flawed, totally lacking in credibility and most assuredly incapable of proving or disproving a disputed medical fact or a contested claim. In order to appreciate the reasons for arriving at these decisions it is necessary to consider a variety of data. These data are discussed below.

2. **Paragraph Two: The Nature of Psychological Diagnoses**

While it may seem rudimentary, many readers of psychological reports do not have any training in mental health disciplines and therefore may be relatively unfamiliar with the nature of psychological diagnoses. For this reason, and because it is important to understand the nature of psychological diagnoses in order to understand my analysis of the doctor’s report, it is necessary to point out that DSM-IV-TR psychological diagnoses are made after considering as many as five different sources of information and to identify these sources as: the patient’s life history and presenting complaints, the doctor’s report of their Mental Status Examination, the objective psychological test data, the patient’s medical records and any sources of collateral information in the form of interviews with the patient’s friends, relatives and/or co-workers or business associates that might exist.

3. **Paragraph Three: A Discussion of the DSM-IV-TR Definition of the Doctor’s Diagnosis**

This paragraph outlines the DSM-IV-TR diagnostic criteria for the disorder that the doctor diagnosed. Essentially, it is necessary to tell the reader what the diagnostic criteria are, since my analysis of the doctor’s report will inspect the correspondence between the DSM-
IV-TR diagnostic criteria and the data that the doctor has provided. The question being examined is, are the data presented by the doctor consistent with the DSM-IV-TR diagnostic criteria of the disorder they diagnosed?

4. **Paragraph Four: A Discussion of the Correspondence Between the History Reported by the Doctor and the DSM-IV-TR Definition of the Disorder Diagnosed**

   This paragraph summarizes and analyzes the history presented by the doctor and draws a conclusion concerning whether or not the data support the doctor’s diagnosis. Obviously, if the doctor did not cite sufficient historical data in the form of complaints made by the patient to meet the DSM-IV-TR criteria, then the report is not credible.

5. **Paragraph Five: A Discussion of the Correspondence Between the Doctor’s Mental Status Examination Data and the DSM-IV-TR Definition of the Disorder Diagnosed**

   This paragraph summarizes and analyzes the Mental Status Examination data presented by the doctor and draws a conclusion concerning whether or not the data support the doctor’s diagnosis. Once again, if the doctor did not cite sufficient Mental Status Examination data to meet the DSM-IV-TR criteria, then the report is not credible.

6. **Paragraph Six: A Discussion of the Testing Data Supporting the Doctor’s Diagnosis**

   This paragraph summarizes and analyzes the psychological testing data presented by the doctor and draws a conclusion concerning whether or not the data support the doctor’s diagnosis. Clearly, if the doctor did not cite sufficient psychological testing data to meet the DSM-IV-TR criteria, then the report is not credible.
7. Paragraph Seven: A Discussion of the Medical Records and Collateral Data Supporting the Doctor’s Diagnosis

This paragraph summarizes and comments on the doctor’s discussion of the medical records and the collateral sources of information. It goes on to comment on whether the doctor provided sufficient data from these sources to support their diagnosis. In many cases there are no medical records or collateral sources of information. In other cases the medical records or collateral sources of information have little bearing on the person’s psychological condition. Nevertheless, if there is a significant discrepancy between the medical records and the collateral sources of information on the one hand, and the doctor’s diagnosis and conclusions on the other, that doctor’s report is not credible.

8. Paragraph Eight: A Statement of the Conclusions I Have Drawn From the Analysis of the Report

This is a summary paragraph. It describes the conclusions I have drawn about the doctor’s report and the exact reasons for arriving at those statements; very briefly summarizing the data discussed in paragraphs two through eight.

II. Substantial Flaws Frequently Found in Psychological and Psychiatric Reports

As I have referred to on many occasions, in 23 years of reading psychological reports I all too frequently have found that they are substantially flawed. Moreover, the medical-legal community is relatively small and most of the doctors who have been doing this kind of work in a circumscribed geographical area become familiar with each other’s reports. However, for reasons I cannot fathom, the same errors tend to occur in the same doctor’s reports year after year after year. I told this to a psychologist I was training and she asked me, “If you point out Dr. Smith’s errors time and time again, how come he still makes them?” I had no adequate explanation other than to suggest, somewhat facetiously, that it was possible that no
one was reading his reports, or maybe no one told him. Regardless, here are some of the most frequently encountered errors.

1. **Inconsistencies Between the Doctor’s Diagnosis and the Patient’s History**

   In order for a report to be credible the doctor’s diagnosis must correspond to the DSM-IV-TR diagnostic criteria. The criteria for the most frequently diagnosed disorders in litigation were discussed above. For simplicity, I have reproduced the diagnostic criteria of a Major Depressive Disorder below. According to the DSM-IV-TR, in order to diagnose a Major Depressive Disorder the patient must present with at least five of nine specific symptoms or complaints. In addition the patient must exhibit Symptom 1 and/or Symptom 2. Also note that of the nine symptoms or complaints eight of them must occur at least “nearly every day.” With all due respect to the many doctors who have diagnosed this disorder without supporting historical data, one does not have to be a rocket scientist to read the reporting doctor’s account of the patient’s history to see if the symptoms or complaints reported by the doctor are consistent with the diagnostic criteria of a Major Depressive Disorder.

**The DSM-IV-TR Diagnostic Criteria for a Major Depressive Disorder**

A. A depressed mood that is present most of the day and every day or nearly every day.
B. A markedly diminished interest or pleasure in all, or almost all, activities most of the day, every day or nearly every day.
C. A significant weight loss or weight gain while not dieting and/or a decrease or increase in appetite every day or nearly every day.
D. Insomnia or hypersomnia every day or nearly every day, which is a lack of restorative sleep or an overabundance of restorative sleep.
E. Psychomotor agitation or retardation, that is, excessive motor activity or a slowing of body movements, respectively, every day or nearly every day.
F. Fatigue or a loss of energy every day or nearly every day.
G. Feelings of worthlessness and/or excessive or inappropriate guilt every day or nearly every day.
H. Diminished ability to think or concentrate or indecisiveness, every day or nearly every day.
I. Recurrent thoughts of death, recurrent suicidal thoughts without a specific plan, or a suicidal attempt, or a specific plan for committing suicide.

Quite simply if there are insufficient symptoms or complaints in the doctor’s history of the patient’s complaints to diagnose the disorder correctly, the report is not credible.

2. Incomplete Histories

On many occasions I have found cases in which the doctor’s history is incomplete. Sometimes they simply do not provide data about a wide variety of issues. For example, they may completely ignore the patient’s marital history and simply name the person that the patient is married to and then perhaps report how long they have been married. The problem here is that they have not obtained any information about the nature of the marital relationship and how it might be affecting the patient’s psychological status in either a negative or positive manner. Another example is that doctors sometimes simply report on the patient’s adolescence by referring to the fact that they graduated high school in a particular year. Once again, the problem is that they have not provided the reader of their report with any information about what may have occurred during that period of the patient’s life that still might be affecting the patient at the time of the doctor’s evaluation. Similar issues of a “thin” history frequently occur in all of the other areas where a comprehensive history must be obtained and reported.

The above discussion notwithstanding, the most serious example of an incomplete history concerns the patient’s complaints. Clearly, in order to understand a person and arrive at a reasonable conclusion concerning their psychological status, it is necessary to obtain a complete listing of the patient’s current complaints, both physical and psychological. It is also necessary to obtain information
about the qualitative nature of those complaints, as well as their frequency, intensity, duration and onset, what I have heuristically referred to as FIDO. It also is important to note any changes in those complaints that may have occurred since their onset as well as any remissions or reinstatements that may have taken place. Without that complete history the doctor’s report is obviously substantially flawed.

3. 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 case of the diagnosis of a Major Depressive Disorder, during a Mental Status Examination the doctor makes observations of not only the patient’s overt physical behavior, but also what they talk about. In this regard, individuals who are clinically depressed may 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, 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 in the context of a Mental Status Examination. Additionally, some of these behaviors, like attention deficits, can be measured with specific techniques that yield easily reported upon objective data. The interested reader is referred to my discussion of a Mental Status Examination in Chapter 4, above. Of course, if there are insufficient data in the doctor’s report to support the diagnosis of a Major Depressive Disorder, the doctor’s report is not credible.
4. 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 the standard in the 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 the reader of the doctor’s 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 fault in the doctor’s report. This is especially relevant since it is possible and normal procedure to test a patient’s memory during the course of a Mental Status Examination. 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 the reader and the court 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.

Finally, as noted above, sometimes doctors fail to include specific sets of data supporting their conclusions about a specific behavior. However, there is another type of error that renders a doctor’s Mental Status Examination incomplete. This occurs when the doctor leaves out entire sections of the Mental Status Examination. In this regard it should be noted that all Mental Status Examination reports should include objective data collected by way of the doctor’s observations using the relatively standard measuring techniques and procedures that provide information about the patient’s orientation, appearance, general behavior, mood, memory attention, cognitive abilities such as reasoning and thinking, general information, communicative ability, possible signs of a major psychological disorder and social ability. Anything less is incomplete.
5. **Flaws in Psychological Testing**

The flaws in psychological testing found in medical-legal reports are so extensive that I am tempted to write a separate chapter on this subject. However, I will just touch on the major issues at this point.

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**a) The Use of Subjectively Interpreted Tests**

Probably the most substantial flaw in psychological testing is the use of subjectively interpreted tests. As discussed at great length in Chapter 6, one class of tests that is subjectively interpreted are projective tests such as the Sentence Completion Tests, the Draw-A-Person Test, the Thematic Apperception Test and, frequently, the Rorschach Test. In each case the person is presented with an ambiguous stimulus or task, such as completing a partially formed sentence, drawing a person or making up a story about a drawing or an inkblot. The underlying assumption is that the way the person completes the sentence, draws the picture or interprets the drawing or inkblot will give the psychologist information about such things as the person’s thoughts, feelings, and attitudes. However, with the possible exception of the Rorschach test, there are no standards for interpreting the patient’s productions (Exner, 1993). Instead, the doctor simply subjectively interprets what he or she thinks the person’s productions mean. Since there is no way of determining if the doctor is correct, the doctor’s interpretation provides absolutely no credible objective data about the patient that can be presented to the court. In essence, the presentation of such test results to the court is at best meaningless, and at worst pseudoscience.

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**b) The Use of Tests That Are Lacking in Validity and/or Reliability**
Another substantial flaw in psychological testing is the use of objective tests, such as questionnaires, that have no validity or reliability. These issues were also discussed in Chapter 6. Essentially, anyone can make up a test in just a few minutes. It really is quite simple. First, let’s pick a name. Let’s call it the “New Jersey Test of Psychopathology.” Let’s also keep it simple and decide it will be a “true-false” test. Now, just write out about 20 declarative statements such as, “I wake up in the morning feeling rested.” “I have a lot of friends.” “I am happy with my job.” “I like my home.” “I have had a good upbringing.” You get the idea! Now let’s talk about scoring. All the questions are written so that a false answer is assumed to be indicative of psychopathology. Now let’s arbitrarily say that if you answer false on ten or more of the questions, you have a psychological disorder. Viola! Now we have the “New Jersey Test of Psychopathology.” It is objective, it is easily scored and it is easily and objectively interpreted. But it is worthless! We have absolutely no idea if it actually measures psychopathology! In order to assure ourselves that it does, we would have to do research to demonstrate that the scores on this “test” are correlated with psychopathology. Unfortunately, there are a multitude of tests on the market that are no better than our “New Jersey Test of Psychopathology.” That is, they have never been shown to actually measure what they purport to measure. Remember, just because a test is out there being sold to psychologists does not mean that it is valuable in assessing psychopathology. But who knows? Clearly, the only knowledgeable person is an expert in psychological testing who is capable of reading the research literature. In short, many of the psychological tests that find their way into medical-legal reports are worthless and completely incapable of providing data about a person’s psychological status. When these tests are used nevertheless, they create a substantial flaw in the doctor’s report.

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

Sometimes, psychologists use valid and reliable tests that research has shown are capable of providing information on a person’s psychological status, but those tests are worthless for use in medical-legal examinations. The issue here is that there is a major
distinction between testing a person in a medical-legal context and testing a person who is not a party to litigation.

In the “normal” psychological practice people typically come to the psychologist for some help in dealing with what they perceive as a problem in their life. Under these conditions it is reasonable to assume that the person is being honest, frank, and straightforward in presenting their symptoms or complaints, since it is in their best interest to do so in order to solve their problem. However, in a medical-legal case one cannot make the assumption of honesty, since it is well known that individuals involved in litigation may very well not be honest and truthful in attempting to obtain a financial settlement. Thus, a psychological test that may be useful in a general clinical or “normal” practice may have absolutely no value in a medical-legal case, unless that test has some method for detecting the credibility of the person’s responses. The methods for detecting honesty of responses on psychological tests are called validity scales. In this regard, the use of a test or tests without validity scales, which have been shown to be capable of detecting honesty or dishonesty, represents a substantial flaw in a psychologist’s report written for the medical-legal community.

**d) Failure to Administer Any Psychological Tests**

The use of objective psychological testing in a medical-legal evaluation is crucial since objective psychological test data are typically the only form of non-subjective information that is open to public inspection and can be presented to the court. Objective psychological test data are almost always obtained in order to assist the diagnosing practitioner in formulating a diagnosis, a prognosis and, if necessary, a treatment plan. The absence of psychological test data from a psychologist’s report is most assuredly a substantial flaw. It means that the doctor most likely provided absolutely no objective data that can be reviewed by an independent and impartial observer that could provide information about the patient’s psychological status at the time that they were evaluated. Viewed in this light, all of the remaining statements in the doctor’s report, with the possible exception of citations of the medical records, are completely subjective.
e) Failure to Report Psychological Testing Data

On some occasions psychologists will administer a battery of tests and proceed to write their report and describe their interpretation of the testing data, often making statements about what those data reveal about the person being evaluated, without presenting the data they obtained. The error in this procedure is that there is no way an independent observer can verify the doctor’s conclusions. While it would be nice to trust all medical-legal reporters, errors are a frequent enough occurrence to require the presence of supporting data. In fact, if data were not required to support the doctor’s conclusions, all that would be necessary in a psychological evaluative report is a single sentence providing the doctor’s diagnosis and a statement of what they believed caused the disorder. For example, something like the following, “I examined Ms. Brown and found that she was suffering from a Posttraumatic Stress Disorder as a result of an automobile accident that took place on July 3, 2007 and left her totally psychologically disabled and in need of extensive psychological and psychiatric care.” Clearly, this would not work in our adversarial legal system.

f) The Misinterpretation of Attempts at Symptom Simulation

As was pointed out above, the MMPI and some other objective psychological tests are capable of determining when a person is attempting to simulate symptoms. Two additional ways of stating this fact are to report that the person was “over-reporting symptoms” or “faking bad.” A somewhat milder comment concerning the attempted simulation of symptoms is to state that the person was “exaggerating pathology.” However, “exaggerating pathology” implies that there was some pathology to exaggerate, a difficult conclusion to arrive at if the testing scores indicate that the person was attempting to simulate symptoms, since such a finding precludes stating anything about their psychological status beyond observing that they were attempting to simulate symptoms.
While it would seem to be a straightforward matter to say that a person was attempting to simulate symptoms when the data support that conclusion, that is not always what happens. For example, one method of discussing attempts to simulate symptoms sometimes taken by overzealous plaintiff or applicant doctors is to state that the patient’s behavior was a “cry for help.” This explanation of the patient’s behavior implies that the patient was asking for assistance by overstating or over-reporting their symptoms or complaints. However, when this explanation is invoked it is very clear that the doctor has confused the issues of what and why. For example, what Mr. Smith was observed to be doing during Dr. Jones’s examination was attempting to simulate symptoms. The “cry for help” explanation is simply a theory that attempts to answer the question of why Mr. Smith was attempting to simulate symptoms. However, the “cry for help” comment is simply one theory about Mr. Smith’s behavior. In this regard, an equally tenable and somewhat facetiously presented theory is that Mr. Smith was “crying for excessive benefits from the court.” Nevertheless, no matter what explanation or theory is cited, nothing can change the fact that Mr. Smith’s testing data indicate that he was attempting to simulate symptoms and Dr. Jones’s failure to distinguish what from why is a substantial flaw in his report.

g) Administering the Psychological Tests Under Non-Standardized Conditions

Unlike the hypothetical “New Jersey Test of Psychopathology” that was discussed above, tests like the MMPI have been standardized. That means that they have been developed in a framework in which the tests results can be meaningfully interpreted only if they are given under the same conditions under which the test was developed. In the case of the MMPI this simply means giving the test with adequate lighting, adequate ventilation and the presence of a test proctor. Probably the most serious flaw in psychological testing occurs when the doctor gives the test to the patient to self-administer at home. When this is done the doctor has absolutely no control over the conditions under which the test was taken or even if the person who was the subject of the evaluation took the test. When I was teaching testing to graduate students at the university I would often tell them stories of my experiences with psychologists who would give
the patients tests to take at home. One of the things I would tell them was that we could never be sure of the findings from tests administered in this manner because we could never be sure that the patient did not give the test to her “Crazy Uncle Charley.” In short, if the doctor does not give the test to the patient in their office under the required testing conditions, absolutely nothing can be said about the psychological testing “data.”

h) Administering Tests That Were Not Designed to Measure Psychopathology

As was pointed out earlier, there are literally thousands of psychological tests. Many of these were designed and standardized for purposes having nothing to do with identifying psychopathology. For example, there is a test called the Millon Index of Personality Styles. This test is not appropriate for use in medical-legal evaluations since it was developed to measure psychological attributes and traits of normal adults (Millon, 1994). Similarly, the Taylor-Johnson Temperament Analysis Scale is not appropriate for use in medical-legal examination, as it was developed for use by counselors to help individuals identify what they see as problems in their lives. While it is tempting to say that such an instrument could be helpful in identifying problems found in medical-legal patients, on page 6 of the testing manual for the Taylor-Johnson Temperament Analysis Scale it is very explicitly stated that it was not “designed to diagnose or identify psychiatric conditions or problems” (Taylor & Morrison, 1984). In short, there are many psychological tests that are inappropriate for use in forensic evaluations and the use of these instruments for that purpose represents a substantial flaw in the examining doctor’s report.

i) Errors in the Use of the MMPI

(1) Errors in Scoring and/or Reporting Test Scores

The Minnesota Multiphasic Personality Inventory (MMPI) is the most frequently used clinical test. Research has demonstrated that it is a highly valid and reliable instrument. The MMPI is usually the cornerstone of every psychological test battery. This instrument can
provide information about the examinee's test-taking attitudes, their credibility, their general level of adjustment, their behaviors, symptoms, attitudes, and the most appropriate diagnostic label. The test also has implications for treatment. The MMPI is especially useful in forensic evaluations because of its ability to detect attempts to simulate psychological symptoms. In this area, a significant advantage of the MMPI is that the test items are not transparent. Even psychologically sophisticated individuals are unable to perceive the true intent of the test items. As I pointed out in Chapter 6, this makes the MMPI relatively hardy in its ability to thwart and detect simulation.

The above discussion of the MMPI would seem to indicate that it would be “foolproof.” However, alas and alack, this is not the case. The MMPI has 566 true-false questions. The scoring of the test requires that the doctor calculate scores on a variety of scales. These scales are called by such names as “Depression,” “Schizophrenia,” “Lie” or in some cases are designated by just letters like “F” and “K.” There are many books devoted just to the scoring and interpretation of the MMPI. These books, as well as thousands of published research articles, discuss a very large number of scales that research has shown have various meanings about an individual's psychological status. Since there are “only” 566 questions on the MMPI, the same question may appear on a very large number of scales. Regardless, each scale can be scored in one of two ways. Let’s say that a mythical scale contains 20 questions and that we need to know how many of those questions were answered “false.” The first method involves putting a simple paper template on top of the person’s answer sheet and counting the number of times the person’s answered “false.” The second method involves entering each of the answers to the 566 questions twice, and letting the computer find any data entry errors and calculate the scores. While mistakes can occur using either method, the second has a much lower error frequency and is therefore preferable.

In writing the psychological testing section of a report it is good form to provide the person’s scores on the test so that the reader and the court can review the doctor’s conclusions or opinions. In fact, in some jurisdictions this is a legal requirement. Unfortunately, a significantly large number of psychological reports provide scores that
are impossible to obtain. For example, the original handbook for the
MMPI provides all of the possible scores for the major scales of the
test (Dahlstrom, Welsh, & Dahlstrom, 1972). An inspection of that
handbook indicates that the scales are not numerically continuous.
For example, a male can obtain a Lie Scale T-Score of 86 and a Lie
Scale T-Score of 83. However, it is not possible for a male to obtain
a Lie Scale T-Score of either 84 or 85! What then can be said of Dr.
Jones’s report when it states, “Mr. Brown received a Lie Scale T-
Score or 84?” Well clearly, Dr. Jones has made a substantial error in
scoring and/or reporting Mr. Brown’s Lie Scale Score. Once Dr.
Jones has made this error it is not possible to conclude anything
about the remainder of what Dr. Jones has said about Mr. Brown’s
MMPI performance, since we do not know what other mistakes are
present in the data.

(2) The “Misinterpretation” of Validity Scale Test Scores

At times doctors completely “misinterpret” scores on tests such
as the MMPI. As previously discussed, one of the principal
advantages of the MMPI is that it has validity scales for assessing the
patient’s test-taking attitudes and credibility. For example, one scale
on the MMPI is called the F Scale. The F Scale is composed of 64
items. Essentially, an elevated score on the F Scale can be obtained
for a number of different reasons. One reason is that the person did
not read the questions. Another is that they did not understand the
questions. A third is that they are “severely disorganized and
psychotic” (Greene, 1980). A fourth is that they were attempting to
simulate symptoms.

In medical-legal cases, it is not unusual to find that a person’s
score on the F Scale is extremely elevated. At times the doctor will
conclude that, “it may be due to the person not reading or
understanding the questions.” However, this explanation is typically
unwarranted and unacceptable. Specifically, prior to administering
the test the doctor or the test proctor must determine if the patient
can understand the questions. This is simply done by having the
patient read a few of the questions and explain to the doctor or the
test proctor what they mean. If the patient cannot do this then the
test should not be administered. Thus, if the test is given one should
be able to assume that the doctor did their job and found out if the person could understand the questions. However, if they did not check the person’s reading ability, they did not do their job properly, and that is a substantial flaw in their examination and report.

Additionally, with regard to the possibility that the person did not read the questions, it is also the doctor’s job to make sure that this does not occur. Essentially, this is quite simple. There must always be a test proctor who watches the person taking the test. This is mandated by the testing manual (Hathaway & McKinley, 1983). If a patient is not reading the questions, but simply randomly or haphazardly filling in the answer sheet, this is easily detectable by the test proctor. Moreover, if for some reason the test proctor fell asleep during the approximately one and a half hours needed to take the test, there is another way of detecting if the patient read the questions. By looking at the scores obtained on the test it is possible to determine if the patient responded in a haphazard or semi-random fashion or if they developed a pattern of responding such as answering the first 100 questions “true” and the next 100 “false” etc. Thus, for the doctor to state that the person may not have been reading the test items is tantamount to the doctor stating they did not administer, score or interpret the test properly. This is certainly another substantial flaw in the testing, the examination and the doctor’s report.

Further, with regard to the possibility that the person received an elevated F Scale score because they were “severely disorganized and psychotic” it should be noted that if this were the case then there should be data in the doctor’s report of their Mental Status Examination of such disorganized and psychotic behavior. There also should be evidence of that behavior in the doctor’s diagnostic conclusions. Thus, the possibility that the elevated F Scale score was due to disorganized and psychotic behavior can be easily eliminated or accepted by reading the balance of the doctor’s report. However, when there is no such evidence in the remainder of the report, the doctor’s comment sticks out like the proverbial sore thumb, revealing a major inconsistency in the doctor’s report that constitutes a substantial flaw in their examination.
Clearly, if the above three possibilities are eliminated it is necessary to conclude that the elevated F Scale score is the result of the person attempting to simulate symptoms. Unfortunately, why this “misinterpretation” occurs is not really a major mystery. Typically, errors such as these occur in the reports from doctors who have been asked to evaluate patients by the plaintiff or applicant’s attorney. While I would like to be able to say that doctors are very honest in reporting in medical-legal cases, the skeptic in me can only wonder how many future referrals would be forthcoming from those attorneys if the doctor was very clear in stating the opinion that the patient was attempting to simulate symptoms on the psychological testing when examined in their office?

Finally, the seemingly motivated “misinterpretation” of the F Scale on the MMPI is not the only place that such misinterpretations occur. There are a variety of other validity scales on the MMPI that are similarly “misinterpreted” for what I believe is the same purpose. Likewise, two frequently used tests that also have validity scales are the Millon Clinical Multiaxial Inventory-III (MCMI-III) and the Cattell Sixteen Personality Factor Test (16PF). In my experience the validity scale scores on these instruments are also frequently “misinterpreted” when the data appear to be unequivocal in indicating that the person being evaluated was attempting to distort their true psychological condition.

(3) The “Misinterpretation” of Clinical Scale Test Scores

Tests like the MMPI, as well as others like the MCMI-III and the 16PF, have had multiple books and thousands of journal articles that have established standards for interpretation. These books and journal articles are public information, not trade secrets, and therefore are well known to professionals in the area. This being true, it still amazes me how frequently the published standards for interpreting tests are violated.

Probably the most grievous error in this area occurs in the interpretation of the MMPI. For purposes of discussion we can think of the MMPI as having two basic types of scales, the validity scales and the clinical scales. As discussed above, the validity scales speak
to the person’s honesty and credibility in answering the test questions. On the other hand the clinical scales speak about the person’s psychological characteristics. The clinical scales are only interpretable once the validity scales have shown that the person took the test honestly. There are ten clinical scales. The standard for interpreting these clinical scales is very clear. Once the person’s scores have been determined, the highest two or three clinical scale scores that exceed a specific known level are found and the pattern of those scores determines what can be said about the person’s psychological status. This has been established by more than 60 years of research that has shown the relationship between the pattern of clinical scale scores and the person’s psychological status. Nevertheless, I am always amazed when I find a doctor who completely ignores this virtually universally accepted standard and “interprets” each of the ten clinical scale scores, making a statement about what each scale supposedly reveals. However, in doing so it is quite clear that they have added a substantial flaw to their report.

(4) Failure to Interpret All of the MMPI Scores

The MMPI has nine validity scales that can be used to establish that the person took the test in an honest and straightforward manner, which will allow for the interpretation of their clinical scale scores. These scales are the Cannot Say Scale, the Lie (L) Scale, the F Scale, the F-K Scale or Index, the K Scale, the Subtle-Obvious Scales, the Revised Dissimulation Scale, the Test-Retest Scale and the Carelessness Scale. Similarly, the MMPI-2 has ten validity scales. These are the Cannot Say Scale, the Lie (L) Scale, the F Scale, the F-K Scale or Index, the K Scale, the Subtle-Obvious Scales, the Revised Dissimulation Scale, the VRIN Scale, the F(p) Scale and the F(Back) Scale. Thus, while there is some question as to the advisability of using the MMPI-2, whether one uses the MMPI or the MMPI-2, all of the validity scales must be within normal limits in order to interpret the patient’s clinical scale scores. However, not all reports by all doctors follow this convention. Thus, it is relatively common to find that a patient has received scores indicating that they did not complete the test in an honest and frank manner and to learn that, although the scores were reported correctly, the doctor chose not to interpret the meaning of those scores correctly. Typically,
when a doctor has done so they go on to make statements about the clinical scale scores and the patient that are not warranted or permitted. Once again, doing so represents a substantial flaw in their procedure and report.

6. Inconsistencies in the Doctor's Report of the Patient's History

A great deal of weight is placed on the doctor’s report of the patient’s history. For this reason it is necessary to collect an extensive amount of data from the patient and to put that information in the doctor’s report. From a diagnostic point of view, if one concludes that a patient has a psychological disorder that is due to either the industrial or non-industrial accident claimed, it is necessary to provide some information indicating that it is not due to some other occurrence. This is a very difficult task. Essentially, it involves proving a negative.

Of course, negatives are difficult to “prove.” For example, how do you prove that little green people don’t live on Mars? Conceptually, the only way to do this is to go to Mars and to explore all areas of the planet, both above and below ground. At this time that is not possible. Nevertheless, it is possible to collect some data to address this issue, even if you cannot prove it in an absolute sense. Clearly, you could do this by determining the content of the Martian atmosphere and showing that people, as we know them, could not survive in that environment. However, “proof” would not be possible as someone could argue that the “little green people” had adapted mechanisms to survive in the Martian atmosphere, thus reinstating the notion that you cannot prove they do not exist.

The same problem with proving a negative is found in drawing conclusions about the causality of psychological disorders. If someone has a disorder, which a doctor has concluded was produced by an automobile accident in July, 2006, it is sometimes difficult to prove that the accident did not cause the disorder. One way is to provide clear and compelling evidence that indicates that
some other incident or factors created the pathology. Another less conclusive method is to obtain data that provides indirect evidence that shows that it is reasonably medically probable that the disorder was not produced by something else. The former method is quite straightforward, and might be arrived at by obtaining data, from the patient’s life history and their medical records, showing that the disorder was present at the same level prior to and after the accident. The latter method is less direct. According to this less direct method, if one obtains a complete and detailed history of the person’s life from the time they were born until the time they entered the doctor’s office, and found nothing that would appear to indicate that any event in their life, besides the automobile accident, could have caused the disorder, then it is reasonable to draw the conclusion that the accident created the problem. However, in doing so one has to collect a large amount of data. Unfortunately, whenever one collects a substantial amount of data it invariably leads to finding inconsistencies that must be resolved in order to have any credibility.

Inconsistencies in a life history can occur anywhere. For example, in taking an employment history the doctor might obtain data indicating that the person worked for the Ajax Widget Company in Houston, Texas between 1984 and 1986. However, in taking the history of where the person lived, the patient may have said that between 1982 and 1985 they lived in LaVerne, Minnesota. While this historical inconsistency may seem trivial, if it is reported by the doctor as factual, it opens the door to the criticism that the report is inaccurate. One can even imagine an attorney asking the doctor in court, “Dr. Jones, if you are wrong about where Mr. Brown lived in 1985, or where he worked during that year, how can you be so sure that the history you reported about the accident is credible and caused his Depressive Disorder?” As the old saying goes, “A chain is only as strong as its weakest link.” Of course, historical inconsistencies in more psychological areas, such as when the psychological complaints started, how often they occur, how intense they are, etc. worsens the doctor’s position and substantially undermines the report’s credibility.

7. Inconsistencies Between the Patient’s Complaints and the Doctor’s Observations
Two sets of subjective impressions are found in each psychological report: the doctor’s report of the patient’s complaints and, to a large extent, the doctor’s report of their Mental Status Examination of the patient. At times these two sets of data are not highly correlated. For a variety of reasons the patient may complain of one thing and the doctor may report having 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 examiner does not even recognize this inconsistency. In these cases, the doctor reports complaints of suicidal thoughts, states they observed no such narrative statements, never mentions the discrepancy and therefore makes no attempt to explain the data.

There are many ways in which these types of inconsistencies can find their way into medical-legal reports. For example, during the Mental Status Examination the doctor may administer tests of memory and find that the patient exhibits some defects in this area, but then directly reports that the patient did not complain about memory problems. 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 expert witness 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 during your Mental Status Examination you observed that Mr. Brown was depressed, but on page 26 you made no mention of Mr. Brown complaining about depression. How can you explain this inconsistency?” While there may be some reasonable explanation for this occurrence, it is best to avoid this problem either first, during the
face-to-face examination of the patient, or failing that, during the course of writing one’s report.

8. Inconsistencies Between the Patient’s Medical Records and the Doctor’s Conclusions and/or Diagnosis

As noted above, information from the patient’s medical records is one of the five basic sources of data used in arriving at the doctor’s conclusions. Unfortunately, there are times when the medical records provide data that are inconsistent with the doctor’s conclusions. A case in point is a patient who provides the doctor with no history of any prior mental health contacts but whose medical records reveal that history. In my experience the most frequent explanation is that the patient has concluded that having had some prior experience with mental health professionals will be damaging to their litigation and declines to discuss that background. A somewhat less frequent occurrence is simply that the patient has forgotten information that is seemingly buried in their records. Regardless, a failure to resolve this issue during the interview, or at least during the writing of the doctor’s report, opens the doctor up to criticism that questions their credibility. Again, we can imagine an attorney on cross-examination presenting the doctor with this obvious inconsistency and using that information to question the doctor’s credibility and therefore all of their conclusions.

9. The Use of Outdated Diagnostic Manuals

As noted in Chapter 1, the first edition of the Diagnostic and Statistical Manual of Mental Disorders was published by the American Psychiatric Association in 1952 and has since been through five revisions as researchers have learned more about the nature of mental disorders. The second edition, called the DSM-II, was published in 1968, and in turn was followed by the DSM-III, which was published in 1980. The next revision, published in 1987, was titled the DSM-III-R and was replaced by the DSM-IV in May, 1994. The current diagnostic manual, the DSM-IV-TR, was published in May, 2000. Each manual has been considered to be the standard
for use in diagnosis, and some jurisdictions are explicit in mandating the use of the most current diagnostic manual in medical-legal cases.

The above being said, one error sometimes made by psychological evaluators is to use an outdated diagnostic manual. Since there have been changes in the definition of some disorders over the years, as well as the elimination of some and the addition of others, the use of an antiquated diagnostic manual opens up the possibility of the doctor making diagnostic errors. It also reveals that the doctor is not current in their knowledge of diagnoses. Clearly, it is a wise expert witness who keeps current and avoids embarrassing questions on the witness stand.

10. Diagnosing Disorders That Do Not Exist

On occasion some doctors have been known to creatively or erroneously provide disorders that are not found in the DSM-IV-TR. Generally, they are not far off from what is found in the DSM-IV-TR, but far enough to make their diagnostic conclusions ambiguous. For example, while there is a disorder called a Depressive Disorder Not Otherwise Specified, there is no disorder called a Depressive Disorder Not Otherwise Specified with Anxiety. Similarly, at times doctors make up diagnostic modifiers. As previously discussed in Chapter 3, the DSM-IV-TR has a specific way of allowing a doctor to report that a patient’s condition has improved. In this regard, the two possible specifiers that the doctor can report are “In Partial Remission” and “In Full Remission.” In Partial Remission is the specifier that is used when the full criteria for the disorder were met at some prior time but at the time of the doctor’s current examination only some of the signs and/or symptoms remain. In Full Remission is the specifier used when there are no longer any signs and/or symptoms of a disorder that was previously found, but it is relevant to note that the disorder existed at some time in the past. This specifier might be used when the doctor wants to make it clear that the patient had a disorder as a result of the automobile accident that occurred in July, 2006, but is recovered and no longer has any signs or symptoms of the disorder. However, when a doctor makes up their own specifiers and states something like, “Depressive Disorder Not Otherwise Specified, greatly improved,” or “Depressive Disorder Not
Otherwise Specified, with some improvement,” they have added ambiguity to their report and created an opening for criticism and questions about their competence and credibility.

Another flaw that falls into the category of creating disorders that do not exist involves the specification of V Codes as evidence of a psychological injury. Probably the most prevalent “diagnosis” in this area is that of Psychological Factors Affecting Medical Condition (316.00). With regard to this “diagnosis,” it should be noted that this condition is not a psychological or mental disorder and its “diagnosis” is irrelevant if one is concerned with the possibility of the patient having a psychological disorder. In this regard, the DSM-IV-TR is very explicit in stating that Psychological Factors Affecting Medical Condition does not constitute a mental disorder. In fact, it is a V Code, which is a concept reserved for conditions that may come to the attention of mental health providers but do not constitute mental disorders. In this regard, Psychological Factors Affecting Medical Condition is a condition characterized by one or more psychological or behavioral factors that are affecting a general medical condition found in the patient. However, if the criterion being used by the court for determining if there has been a psychological injury is the occurrence of a mental or psychological disorder, this condition does not qualify. Accordingly, under these circumstances the mentioning of this condition in the doctor’s diagnostic impressions is irrelevant to establishing a psychological injury and/or a psychological disability.

11. **Basing Conclusions on Outdated Psychological Testing Data**

At times it is necessary for a person being evaluated to have multiple appointments in order to complete the examination. Sometimes this occurs because of a patient’s physical problems that do not allow for them to participate in an examination for an extended period of time. At other times patients simply unilaterally terminate their appointments, providing a variety of reasons such as having another doctor’s appointment, needing to pick children up from school, or simply not wanting to be delayed in traffic at the end of the day. On some occasions the person being evaluated simply takes a long lunch hour, multiple breaks or an extended period of time to
complete the self-paced psychological tests. Clearly, the doctor does not have any control over these factors.

One potential problem that arises from multiple appointments stems from the fact that psychological testing results are time limited. In this regard, testing provides a picture of the patient at the time of the testing, and presumably for some time thereafter. Generally, if a person is given the same test on two different occasions the psychological testing literature shows that the longer the time between test administrations, the greater the differences in the results. This most probably is due to individuals changing over time as well as a lack of reliability in the test itself. The former is especially true for individuals who have a psychological disorder and are in treatment, as the treatment can be expected to produce changes in the person’s behavior. Thus, although there is no generally accepted standard in the community, for purposes of evaluation for the courts, it appears reasonable to assume that approximately 60 days is the “shelf life” of psychological testing.

The above discussion notwithstanding, there are times when doctors have written reports that have completely ignored the issue of the time limitation of psychological testing reports. In many of these cases a doctor will see a person for an initial evaluation, and then, usually after some period of time during which the patient receives treatment, the doctor will see them for another evaluation. In some of these cases the time between evaluations might be as much as a year. Unfortunately, there are occasions when the doctor will not re-administer the tests at the time of the second evaluation, but use the original data to make statements about the patient. Clearly, this is a substantial error that seriously questions the credibility of the doctor’s second and usually final report.

12. Doctor-Made Statements Indicating They Have Not Collected Enough Data to Make a Diagnosis

I have talked about the issue of doctors not collecting sufficient information to make a diagnosis and pointed out that defects in the information gathering process can occur in the taking of the patient’s history, the doctor’s Mental Status Examination and the psychological
testing. In fact, there are many times where the doctor will directly state that they have not obtained sufficient information to make a diagnosis. When put into “professional language” these statements are sometimes not easily detected.

One way a doctor has of admitting that they have not collected enough information to understand the patient’s psychological status is to use a “vs.” diagnosis. For example, the doctor may “diagnose” a “Depressive Disorder Not Otherwise Specified vs. a Major Depressive Disorder.” In simple language this is the same as saying, “I’m not sure which of these two disorders the patient has.” While the doctor is stating their opinion that the patient is clinically depressed, by using the concept “vs.” in providing their diagnostic conclusions they are stating that there is ambiguity or uncertainty in their diagnosis. This is simply an indirect way of stating that they do not understand the patient or their condition. Generally, the doctor never explains why he or she is not certain of their diagnosis, nor does the doctor state why he or she did not obtain additional information to reduce the ambiguity. However, what is clear is that the diagnostic uncertainty by using the term “vs.” represents a substantial flaw in that document.

“Rule-Out” diagnoses are another way doctors have of stating that they do not understand the patient. For example, in providing their conclusions doctors sometimes state, “Rule-Out, a Generalized Anxiety Disorder.” In this regard, a “Rule-Out” diagnosis is simply a statement that they wish to eliminate or exclude the possibility of a Generalized Anxiety Disorder, but have not yet done so. Typically, the doctor does not provide any insight or comment as to why they chose to write their report without having “ruled out” or “ruled in” the disorder, nor do they usually state what they plan on doing in the future to reduce the uncertainty. Nevertheless, it is quite clear that by using a “Rule-Out” diagnosis the doctor is stating that they do not understand the patient’s condition. Clearly, this is a substantial flaw in their report.

Another way to express diagnostic uncertainty and to admit to a lack of understanding of the patient is for a doctor to “defer” their diagnosis. “Deferred” diagnoses may appear on Axis I as well as on Axis II. According to the DSM-IV-TR, a “Deferred” diagnosis is only used when the doctor has “Information inadequate to make any
diagnostic judgment" about an Axis I diagnosis or condition or an Axis II diagnosis. As is true with other types of expressed diagnostic uncertainty, in cases in which the doctor has chosen to defer their diagnosis they typically do not explain why they have done so, nor do they describe why they have chosen to write their report without obtaining adequate information. However, it is apparent that this form of diagnostic uncertainty also constitutes a substantial flaw in their report.

Additionally, diagnostic uncertainty can also be found in reports where doctors provide “Provisional” diagnoses. As noted in the DSM-IV-TR, the specifier “Provisional” is used when there is a strong presumption that the person will ultimately meet the full criteria for the disorder, but at the time of the doctor’s examination there was not enough information to make a “firm diagnosis.” While this type of reporting may be a reasonable way of communicating in a non-forensic case, it clearly reflects the doctor’s admission that they do not understand the patient’s condition. In a medical-legal context one must then ask why the doctor chose to write their report without obtaining the needed information to understand the patient. Under these circumstances the doctor who has chosen to do so can expect that their report will be criticized on this basis as containing a substantial flaw.

One final way in which doctors create diagnostic uncertainty is by introducing ambiguous terms in their formal diagnosis. For example, one recent report I read noted on Axis II, the axis on which Personality Disorders are diagnosed, “No clear personality disorder.” Unfortunately, the DSM-IV-TR does not recognize this term or provide the doctor with this option. Specifically, the DSM-IV-TR allows the doctor only three options. First, they can diagnose a Personality Disorder or some form of Mental Retardation. Second, they may offer a “Deferred Diagnosis.” And third, they can state “No Diagnosis on Axis II,” indicating that the doctor has concluded that the person does not have a Personality Disorder and is not mentally retarded. In the above-mentioned case the doctor’s use of the word “clear” in stating that they believe that there is “No clear personality disorder” indicates uncertainty in the doctor’s diagnostic conclusions since it implies that a Personality Disorder may be present, but they were unclear or uncertain about its existence. Once again, this raises
the question as to why the doctor chose not to obtain sufficient data to reduce the uncertainty. Nevertheless, by not obtaining the needed data the doctor has introduced a substantial flaw in their report.

III. Treating Psychologists and Treating Psychiatrists Reports

On occasions I have had the opportunity to review reports from treating psychologists and psychiatrists. These are documents that are intended to report on the progress of a patient in treatment and are not meant to be expert witness reports. As such, these reports cannot be judged by the same criteria used to evaluate medical-legal reports. Nevertheless, they often contain some data relevant to understanding the patient, although they cannot be expected to contain comprehensive histories, complete Mental Status Examination reports or extensive psychological testing data.

IV. Psychological Testing Reports

Psychological testing reports are generally written by a psychologist and provide only psychological test results in arriving at conclusions about the patient. Typically, these reports are written at the request of a psychiatrist who has referred the patient for psychological testing to provide the psychiatrist with additional information about the patient. Psychological testing reports typically do not have much in the way of Mental Status Examination data, historical data, a review of medical records, or a discussion of collateral sources of information. Although these areas are often touched upon, they are treated in a rather cursory fashion. In fact, it is not unusual to find that the psychologist never had a face-to-face interaction with the patient but used an objective psychological test battery administered by a test proctor. Nevertheless, the doctor writing the psychological testing report will often provide a diagnosis. However, in light of the absence of a complete history as well as Mental Status Examination data, a review of medical records, and a discussion of collateral sources of information, any such diagnostic conclusions are not credible since psychological testing by itself cannot be used to provide a valid and reliable psychological diagnosis. All one can do in these cases is to comment on whether
the tests used were valid, reliable and objective; whether the tests the
doctor administered are capable of assessing the credibility of the
patient’s responses; whether the patient appeared to take the tests in
an honest and straightforward manner; whether there is evidence
indicating that they were given under standardized conditions;
whether or not the doctor provided all of the necessary data to review
their opinions; and whether there were any obvious errors in the
scoring or reporting of the data; as well as to comment on the
appropriateness of the conclusions drawn. In regard to the latter,
since no attempt is usually made to conduct a complete examination,
any diagnostic conclusions are inappropriate and, at best, should be
considered to be hypotheses to be checked by the doctor who
administers the majority of the examination.

V. Psychological and Psychiatric Reports Written by Non-
Doctors

There are a variety of practitioners who may write reports of a
psychological nature that draw some conclusions about a patient’s
psychological status. These individuals are: Marriage and Family
Therapists, Licensed Clinical Social Workers, Social Workers,
Substance Abuse Counselors, Pastoral Counselors, Nurse
Practitioners, Physician’s Assistants and Registered Nurses. In many
cases they make DSM-IV-TR diagnoses and other statements about
the individual’s psychological status and need for treatment. In many
cases they are counseling the patient or referring them to other
professionals who do treatment.

In discussing these reports in a review of medical records,
depending on the jurisdiction, it is best to point out to the court that
they were written by individuals who are not licensed to practice
either psychology or psychiatry and then to go on to review them in
terms of the criteria used to judge a report of a complete medical-
legal evaluation written by a psychologist. As you might expect,
reports written by these individuals typically contain multiple
substantial flaws.

Additionally, it should be noted that many of the above-
described professionals, as well as other non-psychological and non-
psychiatric professionals, often describe patients in their notes or records as “depressed” or “anxious.” In this regard it is important to keep in mind that both lay people and untrained mental health personnel frequently use those words to describe feelings that the patient may be having that are normal for their circumstances and therefore are not indicative of a psychiatric disorder. Accordingly, in the absence of a complete examination by a trained and qualified psychologist or psychiatrist it would be a substantial error in clinical judgment to conclude that any such comments appearing in the medical records are indicative of a psychological disorder.

VI. The Meaning of Prescribing Psychotropic Drugs

On occasions I sometimes encounter medical records indicating that some medical practitioner has prescribed a psychotropic medication for an individual I am evaluating. A review of the literature indicates that non-psychiatrists, such as family practitioners, general practitioners and orthopedists, prescribe a large proportion of psychotropic drugs like anti-depressants and anti-anxiety medications. While it is tempting to conclude that a patient has a psychological disorder that needs treatment solely on the basis of such a prescription, such a conclusion is seriously flawed by the absence of a complete examination indicating that the medication was needed to cure or alleviate the affects of a DSM-IV-TR psychological disorder. Accordingly, in commenting on such records I will typically indicate that there are no data in the records showing that the person who prescribed the medication conducted a complete psychological or psychiatric examination of the patient, arrived at a tenable DSM-IV-TR diagnosis or is a trained or qualified practitioner in either psychology or psychiatry.
Chapter 10

The Summary and Conclusions

The purpose of this section of the report is to summarize what has been found about the patient’s psychological status with regard to their litigation and to cite the data that support those conclusions. While there are many formats that can be used to summarize one’s findings, in the paragraphs below I will describe the essential information that should be in every report as well as the particular style that works for me. Overall, this section of the report should be no more than two or three pages long. In reviewing other doctor’s reports, I find that as their summaries get longer I become more confident in concluding that the doctor does not have an understanding of the patient and is trying to “bury” that uncertainty with a lot of words. The notion of keeping things simple and getting to the point has been around since the 14th century and is sometimes called the Law of Parsimony, which simply states, “the simplest explanation is usually the best.” It has also been said, “The ability to simplify means to eliminate the unnecessary so that the necessary may speak” (Hoffman, Weeks, & Bartlett, 1967).

At this juncture, I would like to point out that one of the most important things in writing a Summary and Conclusions section is to assume that the reader knows very little about psychology. It is important not to lose sight of the fact that with the exception of psychologists and other mental health professionals; the people who read psychological reports are attorneys, insurance adjusters and judges who cannot be expected to be experts in this area. Nothing can obscure an otherwise excellent evaluation more readily than a lot of professional jargon. Thus, if I ever find myself slipping into “jargonese” I remind myself that if I cannot explain the patient, their condition and the circumstances that brought them to my office in simple terms, I probably do not understand the patient well enough and therefore will never be able to get anyone else to understand the person.
Without doubt every Summary and Conclusion should answer each of the following questions in simple and direct terms:

1. What is the diagnosis?
2. What is the DSM-IV-TR definition of the diagnosis?
3. What support does the Mental Status Examination provide for the diagnosis?
4. What support does the person’s Life History and Presenting Complaints provide for the diagnosis?
5. What support do the testing data provide for the diagnosis?
6. What support do the psychological and medical records provide for the diagnosis?
7. What demonstrable shortcomings are to be found in psychological reports authored by “the other side”?
8. What support, if any, do the collateral sources of information provide for the diagnosis?
9. What data, if any, from the Mental Status Examination, the Life History and Presenting Complaints, the psychological testing, the medical records, and the collateral sources of information do not fit readily into the conclusions of the report. and how can those data be explained?
10. Does the person have any psychological disabilities, and if so, how severe are they and are they temporary or permanent?
11. Does the person need, or have they needed, any psychological and/or psychiatric treatment, and has any such treatment been effective?
12. To what extent has the subject of the litigation caused the disorder, disabilities, need for treatment, and the discomfort, pain and suffering, if any, and to what extent have others factors played a causative role?

As noted above, the initial step in providing a Summary and Conclusion is to describe the person’s DSM-IV-TR diagnostic status. In simple terms, do they have a disorder or are they normal? Let’s follow those two possible paths.
First, let’s look at a case in which the person has a disorder. In this particular case, as described on Axis I, below, Mr. Brown has been found to have a Depressive Disorder Not Otherwise Specified (311.00). On Axis II he was found to have no Personality Disorder or Mental Retardation, hence the specification of “No Diagnosis (V71.09).” There is a statement on Axis III indicating that the doctor has concluded that the only physical disorders or conditions relevant to an understanding of Mr. Brown’s psychological condition are the orthopedic problems stemming from the automobile accident of July 26, 2007. On Axis IV the doctor points out that there are no data supporting the notion that psychosocial and/or environmental problems have affected Mr. Brown’s psychological disorder. Finally, Axis V is used to depict the patient’s Global Assessment of Functioning. The Global Assessment of Functioning describes the individual’s overall level of functioning, which takes into consideration their psychological, social and occupational functioning but not their physical functioning. Global Assessment of Functioning is conceived of as a variable extending from 1 to 100 that describes the patient’s overall level of functioning. The higher numbers correspond to higher levels of functioning and vice versa. The DSM-IV-TR provides definitions of this 100-point scale at 10-point intervals. In this regard, Mr. Brown was said to have a current Global Assessment of Functioning of 80 and the highest Global Level of Functioning that he exhibited during the past year was also 80.

Axis I - Depressive Disorder Not Otherwise Specified (311.00).

Axis II - No Diagnosis (V71.09).

Axis III - Physical Disorders and Conditions: It appears likely that Mr. Brown’s orthopedic problems, which his records indicate were produced by the automobile accident of July 26, 2007, have precipitated and maintained his clinical depression.
Axis IV - Psychosocial and Environmental Problems:
No known psychosocial or environmental problems relevant to an understanding of Mr. Brown’s psychological disorder.

Axis V - Global Assessment of Functioning (GAF).
Current GAF: 80. Highest GAF Past Year 80. Mr. Brown is capable of functioning in his normal areas of interest and activities although he has some minimal psychological disabilities.

Now that we have seen what a DSM-IV-TR five Axes diagnosis looks like for a disordered person, let’s see what one looks like for someone who does not have a disorder. Clearly, there is not much difference.

Axis I - No Diagnosis or Condition (V71.09).

Axis II - No Diagnosis (V71.09).

Axis III - Physical Disorders and Conditions: Not applicable when the patient has no psychological disorder.

Axis IV - Psychosocial and Environmental Problems: Not applicable when the patient has no psychological disorder.

Axis V - Global Assessment of Functioning (GAF).
Current GAF: 90. Highest GAF Past Year 90. Mr. Brown has no psychological disorders or disabilities. He is capable of a high level of functioning in his normal areas of interest and activities. He maintains his normal level of satisfaction with life.
Once having summarized the patient's diagnostic status, it is absolutely mandatory to describe in detail the DSM-IV-TR diagnostic criteria for the disorder. As noted above, with the exception of mental health professionals, the readers of psychological reports are attorneys, insurance adjusters and judges who cannot be expected to be experts in the area. Accordingly, if they are told that Mr. Brown has a Depressive Disorder Not Otherwise Specified, they may not have any idea what that means, unless they are given the specific DSM-IV-TR diagnostic criteria for that disorder. Only when given those criteria is it possible to compare those criteria with the Mental Status Examination data, the historical data including the patient’s complaints, the psychological testing data, the medical record data and the collateral sources of information and determine if there is sufficient evidence in the doctor’s report to support the diagnosis.

Once having summarized the patient’s diagnostic status and any relevant DSM-IV-TR diagnostic criteria, it is necessary to provide the evidence that supports whatever conclusions were drawn. In the case of the patient who has a disorder, it is necessary to cite the specific evidence from the patient’s life history and presenting complaints, the Mental Status Examination, the psychological testing, the medical records and any collateral sources of information that support the conclusions. In the case of the person who does not have a disorder, it is necessary to provide exactly the same sources of data to support the conclusion that there has been no disorder, and that that person’s psychological reactions to the accident were normal, reasonable, understandable and expectable. Essentially, regardless of the patient’s diagnostic condition, what must be done is to answer the general question, what data support the diagnostic conclusions?

While everyone who does forensic work would like all of the data in their cases to fit their conclusions, the reality of this work is that there are times when not everything appears to fit. At these times, the most dangerous thing for a forensic examiner to do is to try to ignore the inconsistencies and sweep them under the rug. Needless to say, that will be the first place “the other side” will attack the doctor’s credibility. As a medical-legal examiner one can expect that “the other side” will be ruled by the saying, “Falsus in uno, falsus in omnibus.” “False in one thing, false in all.” Accordingly, if there
are any data that do not appear to conform to the conclusions, it is necessary to describe those data and provide the reader with an explanation of why those data were obtained and what they mean. Clearly, it is better to point out these problems than hang on to the hope that “the other side” won’t notice if the data are swept under the proverbial rug!

Inconsistent data may arise from any of the five sources of information. For our purposes, it is only necessary to consider a few examples. One such case occurs when a person’s psychological testing is inconsistent with their Mental Status Examination performance. For example, there are times when the psychological testing reveals a person who has an average or somewhat above I.Q. but performs quite poorly when asked to do simple arithmetic problems, or simple identifications of similarities on the Mental Status Examination. Since the Mental Status Examination and the I.Q. tests measure the same things, the simplest explanation of this inconsistency is that the person was deliberately trying to perform poorly on the Mental Status Examination. Quite simply, there is no way that one can “accidentally” get a high score on an I.Q. test any more than they can spuriously run a 9.4 second hundred meter dash.

Additional inconsistencies also can be found between the overall face-to-face clinical interview and the psychological testing. For example, on occasion a patient will present with an obvious and severe clinical depression during the clinical interview, but during the psychological testing will generate clear and compelling data indicating that they were attempting to simulate symptoms. Similarly, there are times when people will steadfastly maintain that they do not have any symptoms or complaints, and have not had any after the accident that resulted in their litigation. Nevertheless, their test results will also indicate that they were attempting to appear to have psychopathology that does not exist. In the first case, the most likely explanation is that the person has a disorder and is “putting icing on the cake,” perhaps trying to make sure that their pathology was not overlooked. In the second case, it is likely that the person does not have a disorder but was trying to appear to have psychopathology when they took the tests but got “cold feet” during the interview or did not know how to present a cogent history consistent with a disorder. However, from the point of view of both the psychologist writing the
report and the reader of that document, the most important thing is that there is an explanation for the apparent inconsistency.

Another frequent inconsistency found in medical-legal examinations involves discrepancies between the patient’s complaints and the Mental Status Examination data and the remainder of the face-to-face clinical interview. One such example occurs when an individual complains about being severely depressed “all the time,” but during the doctor’s Mental Status Examination and the rest of the interview there are few or no narrative statements or behavioral observations consistent with a depressed person. In these cases, the most parsimonious explanation is that the patient was paying lip service to or embellishing their complaints during the history taking, but had no idea and/or ability to portray a depressed person during the face-to-face Mental Status Examination procedures. A similar type of inconsistency occurs when the individual clearly appears to be clinically depressed during the Mental Status Examination and the remainder of the face-to-face interview, but denies any and all complaints consistent with a depression during the history taking. This inconsistency is usually most easily resolved by noting that for one or more of a variety of psychological reasons the patient has attempted to maintain a façade of mental health. This type of behavior is usually called denial or defensiveness and requires a particularly insightful and comprehensive interview in order to find the relatively subtle clues that will reveal the pathology and resolve the apparent inconsistency.

One final example concerns inconsistencies that stem from the patient’s medical records. In these cases there will be psychological or psychiatric reports that arrive at diagnostic conclusions that are completely inconsistent with a variety of data from other sources. Experience has shown that most frequently these inconsistencies are due to shortcomings in the medical records where disorders were misdiagnosed or missed. In most of these cases, a reading of the psychological or psychiatric reports will reveal sufficiently substantial flaws in those documents to explain the discrepancies. On these occasions a detailed discussion of those flaws usually puts the issue to rest.
Once again, as noted above, keep in mind that inconsistencies such as the above can occur in any area. Things that do not seem to fit may be found in the history, the Mental Status Examination, the medical records or in the collateral sources of information. However, regardless of where the inconsistencies arise, the manner of dealing with them remains the same. They must be accounted for with a reasonable explanation. While this is almost always possible, there are very rare circumstances when there may not be a plausible explanation. In these unusual cases it is best to point that out in the report. Additionally, it is sometimes possible to request and obtain additional information from a source not available at the time of the examination that may clarify the ambiguity. These data may be in the form of some additional medical records, perhaps an investigative report or possibly an opportunity to interview someone who may have a unique perspective on the patient.

Going back to the straightforward case of the patient who has a disorder that is confirmed by all of the evaluation’s data, the next task is to describe the cause of that disorder. Specifically, the question that must be answered is, how did the person get that way? In most circumstances the person’s history and their medical records will provide the majority of the data addressing this question. Very frequently there is a direct connection between the accident and the disorder. For example, you may be able to cite historical data, as well as medical record data, showing that Mr. Brown was doing just fine at work and in his leisure life, engaging in his normal activities without any problems, until the accident that caused him physical harm that subsequently led him to get depressed about his condition. In other cases the chain of causality will not be quite so clear. In these cases perhaps Mr. Brown had some psychological problems with depression or substance use prior to the accident. Perhaps he even was being treated for alcoholism and/or depression prior to getting hurt. In these cases the cause of Mr. Brown’s current level of pathology may be a combination of his pre-existing problems and the accident. When this occurs it is necessary to try to attribute the causes of his current condition to the two or more factors that are operative. Clearly, this will involve an analysis of Mr. Brown’s history, the contents of his medical records and any collateral sources of information that can provide data about his pre-morbid functioning. Having conducted that analysis, it is necessary for the doctor to
discuss the specific reasons that led them to draw conclusions about the relative contributions of each of the causes of Mr. Brown’s current psychological problems.

Having drawn some conclusion about the cause of the patient’s disorder, the doctor’s next step is to discuss any disabilities the person may have. This discussion of the disabilities is relevant to the court when the issue is compensation for those lost abilities, with money or some other form of benefits. At this juncture it is appropriate to point out the behaviors that the person can no longer perform and compare them to the behaviors they were capable of before the injury. Of course it is not a psychologist’s job to deal with the physical elements of disability, just the psychological elements. So, if the person is depressed and has some disability relating to other people because of this depression, it will be helpful to the court to be informed of the manner in which this psychological disability expresses itself and to compare this disability to the individual’s premorbid level of functioning. Further, it is also relevant in some jurisdictions to discuss the emotional impact that the injury has had on the individual that is independent of any disabilities they may have, so that if the court is inclined to compensate the person for any discomfort, pain and suffering they may do so.

Having dealt with the issue of disability and psychic pain, it is best to turn to the issues of treatment. In this regard I typically ask myself a series of questions and then provide answers. For example: What, if anything, do I believe can be done to alleviate the person’s disorder and/or disability? How much treatment do I think it will take before some level of maximum improvement is achieved? Do I think some level of treatment will be needed in the future to maintain the person’s level of functioning and well-being? How about any treatment they may have already had? Was it necessary? Was it reasonable to administer that treatment, given what I know about the patient? Of course, all of the answers to these questions must be supported with data and explanations that are simple and to the point.

Additionally, but most importantly, I discuss the patient’s psychological and other mental health records. Again, I find myself asking and answering questions such as: Do I agree with the other doctor or doctors who have examined the patient? If so, why? If not,
why not? If I found substantial flaws in that doctor’s report, what specifically are those flaws and how do they impact that doctor’s conclusions? Are those flaws sufficiently substantial to discredit the doctor’s report? If so, why? What data support that conclusion? As with all of the other conclusions, an analysis of the available data and the bearing that they have on the conclusions reached by myself and any other doctors are the most important part of this discussion. Moreover, during that discussion it is absolutely essential to outline all of the reasons given for arriving at all of the conclusions. A Summary and Conclusions in which a doctor simply gives an opinion, or what is called a summary conclusion, without any support is worthless. Clearly, the Summary and Conclusions always should be written in such a way that all of the major conclusions are pointed out in a succinct and clear manner and all of the data supporting those conclusions are presented. In fact, if I have done my job properly, the only time it may be necessary to read the bulk of the report is to search for specific pieces of data supporting the broad picture painted in the Summary and Conclusions.

Finally, I always keep in mind that my reports are being written for litigation. While in some cases I may be the only doctor reporting, since both sides have agreed to abide by my opinion, in most situations there are doctors on both sides. When this is the case I keep it in mind when I write my report that if an attorney has to go into court and prove something they will have a document and testimony that will not only provide a professional opinion about the patient and the doctors on “the other side,” but the report will be well-reasoned, supported by data and, if the facts support it, show exactly why “the other side” is wrong. Moreover, while writing my reports I always think about proving my conclusions to a judge and jury by citing all the data that support those conclusions and the reasoning that led me there. In fact, while writing the entire report I imagine myself being criticized and cross-examined by the attorney on “the other side.” Generally, I ask myself: What can they possibly say? How can they refute what I have said? More specifically, I imagine the cross-examiner saying such things as, “Dr. Leckart, what evidence is there that you took a complete history?” “Dr. Leckart, what data led you to conclude that Mr. Brown was not being honest in responding to the tests?” Then, within the limits of the case and reality, I write my report with answers to their anticipated arguments and criticisms.
However, by that time, by using this self-critical process, I have typically found any weakness in my formulation of the case and have changed that formulation to fit the facts.
Chapter 11
For Psychologists Only: How to Build a Practice

You may be the most sensitive, intuitive, communicative and intelligent psychologist in the entire universe, conduct the most professional evaluations, and write the best report ever seen, but if you do not get referrals, you do not have a practice. This section is written specifically to tell you how to build a practice from virtually nothing, without anyone's help.

The first thing you must do is to recognize where the referrals come from. In a medical-legal practice there are only two sources of referrals: attorneys and insurance adjusters. In every litigation there are two sides. In personal injury cases there is the “plaintiff” and the defendant, which is typically the insurance company. In workers’ compensation cases there is the “applicant,” or injured party, and typically the insurance company. In workers’ compensation as well as personal injury cases the insurance company is usually referred to as “the defense.” This makes a lot of intuitive sense, since the insurance company is defending against a claim.

Litigation is an adversarial process. Each side fights to overcome or win against the other. With a single exception, which I will discuss below, in any given case a doctor may be chosen as an expert witness by one side, or the other. In both personal injury and workers’ compensation it is possible to work for both sides on different cases, although most doctors usually find this difficult. The difficulty arises because most psychologists, whether they realize it or not, are either conservative or liberal in their approach to what is a disorder. They also typically have liberal or conservative feelings with respect to the two sets of adversaries. In this regard, it is best to decide how you feel about disorders, diagnoses, plaintiffs, and insurance companies and pick one side or the other based upon your own sense of values and proclivities. If you tend to be fairly liberal in your approach to what is a disorder and what is not, and if you do not have much love or respect for insurance companies but like the underdog and fighting for the individual and the “little guy,” standing up for the rights of those who have few people to stand up for them, you are probably best working on the plaintiff or the applicant’s side.
On the other hand, if you think people tend to see everyone as having a disorder and that people who file lawsuits are not only destroying an important part of our society with excessive litigation, but tend to be “whiners” looking for something for nothing, you are probably best working for the defense. Of course, these are the extremes. Moreover, there are other reasons for working for one side or the other; these are just some of the ones that come to mind.

I mentioned that there is one exception to picking a side. This is the case of agreed medical examiners or what are sometimes called independent medical examiners. Specifically, in some jurisdictions and under some circumstances, the parties to litigation will decide it is in everyone’s best interest, or the civil laws will be such that only one doctor is selected, to conduct the evaluation. When this occurs, the two sides will either agree to accept what the doctor says without any arguments or are bound to accept the doctor’s opinion as a matter of law. So, you can have it any way you want it. You can work for one side or the other, or try to get cases where both sides want you to do the work.

Regardless of what type of a practice you want, the way you get cases referred to you is still the same. Very simply, you talk to people who have the cases to refer to you and convince them that you will be able to do a good job for them. Before starting to make personal contacts it is best to have some sample product to show your prospects. Since what you will be doing is writing reports, you will want to have a sample report. If you have never written one before, arrange to find what some authority has told you is a good report and then modify the format to fit your style. Then find or construct a case, perhaps one from your already existing practice or internship, and write the report. Of course you will want to change all the names and events sufficiently so that no one can identify any of the people, places or institutions in your fictitious report. Most importantly, if I can give you only one piece of advice, it is to avoid professional jargon at all costs. While you may be tempted to think that a high level of professional and technical language will impress people, it will not. All it will do is obscure what you have to say and confuse the people who will send you referrals. Save that dialogue for your colleagues. Additionally, do not lose sight of the fact that this report is what you will be selling, and make no mistake about it, you
will be selling your report as well as yourself. Finally, besides having a “hot shot” report you will also need a “hot shot” resume, *cv* or *vita*, as well as an ability to persistently approach people and tell them about your work and yourself.

One way of promoting yourself also has the important benefit of providing you with information about how the system works. One thing I can recommend is going to court and sitting in on a case that has a psychological component. See who is doing the work. See what they have to say when called to the witness stand. In workers’ compensation in California the doctor almost never goes to court but testifies with their report. Nevertheless, go to the workers’ compensation court or a civil court and watch the proceedings in a case in which at least a part of it consists of a psychological claim. After the hearing is over, approach one or more of the attorneys and introduce yourself, tell them you are just getting started doing medical-legal work and thought you would observe the proceedings and ask them if they would mind if you asked them some questions. Be prepared for, “Not right now, I have another appointment.” But also do not be surprised when you hear, “Sure, I’d be happy to.” If appropriate, invite them to lunch. Pick up the check. Do not try to be anything you are not. Be honest. A similar approach can also be used on the judge in the case. Go to the judge’s chambers and introduce yourself. Tell them the same story about just getting started and ask them if they would mind you asking some questions. Be sure to remind yourself it is a numbers game. If the first judge does not respond in a positive way, then perhaps the next one will, or maybe the one after that. All you need is one lawyer or one judge to set you on your way. As for the questions you will ask at these meetings, just ask the things you know nothing about. Given your lack of experience, they will be numerous.

Another approach that is useful, but only for seeking defense work, is to contact the insurance companies directly. Insurance companies sometimes are so large that they have hundreds of adjusters who may handle as many as 300 cases at a time. In those companies there is invariably a training director, who may have a different title, but who is responsible for seeing that the adjusters are brought up to and maintain a level of skill that will help them settle cases, presumably to the insurance company’s advantage. Introduce
yourself to the training director and offer to come speak about some
topic relevant to psychological claims that will help the adjusters do
their job. One topic of mine that is a favorite is “Understanding the
Nature of Psychological Evaluations.” Essentially, if I have done a
good job writing this book, you simply go into the talk and tell them
what I’ve told you. Do not give me credit. The marketing is for you,
not me. I already have enough work and do not need more. Another
topic is psychological testing. I suspect that with very little effort you
can take the material in this book and create a one-hour presentation
on psychological testing. Tell them exactly where doctors on the
other side make mistakes and how you can find those errors and
what they mean about the claimant and their case. Hand out the
sample copy of your report, your resume and your business card. If
you feel very assertive you can pass around a pad and get a list of
adjusters in attendance and promise to put them on your mailing list
for a newsletter that you will write to keep them up to date on events
in forensic psychology. Do not be shy. Feel free to make friends. In
many jurisdictions it is not a violation of law or ethics to take an
adjuster to lunch!

Another approach that works with attorneys is simply to go on
the Internet and obtain the names and phone numbers of attorneys in
your geographical area who do personal injury or workers' compensation litigation for either the defense or the applicant/plaintiff side. Call them up and, if you find them or their paralegals receptive, send them a sample report and a resume. After waiting about a week call them again and ask them what they thought of your material. Most will not be enthused or even take your call. However, every once in a while someone will take a liking to you, perhaps because of your sparkling personality or perhaps because the sample report you sent them is better than anything that has ever come across their desk! Invite them to lunch. Get to know them and vice versa. This cannot fail.
**Glossary**

**affect** - observable behavior or signs indicative of an individual’s subjective feelings or mood (contrast with “mood”)

**agnosia** - the failure to recognize or identify objects despite intact sensory function

**aggravation** - an increase in the signs and/or symptoms of a physical or psychiatric disorder

**all reasonable medical probability** - more than half the time

**alogia** - as seen in Schizophrenia it is observed as an impoverishment of thought and/or speech

**amenorrhea** - the absence or the abnormal stoppage of menses

**anhedonia** - a loss of interest in pleasure

**aphasia** - a deterioration of language functioning in which an individual is said to have difficulty producing the names of individuals and objects – aphasic speech may be vague or empty, with long, roundabout or circular phases and excessive use of terms of indefinite references, such as “thing” and “it”

**apraxia** - the impaired ability to execute motor activity although there is no paralysis or other motor or sensory impairment and the person understands the task’s requirements

**autism** - a pervasive developmental disorder characterized by a major impairment in social interaction and communication, and stereotyped or restricted patterns of behavior, interests and activities that occur before the age of 3

**autonomic arousal** - arousal of the autonomic nervous system

**autonomic hyperactivity** - overactivity of the autonomic nervous system
**autonomic nervous system** - that part of the nervous system that controls involuntary and vegetative systems such as the cardiovascular, digestive and respiratory systems

**avolition** - a sign and/or a symptom occurring in Schizophrenia that is observed as an inability to initiate or sustain purposeful activities

**catatonic motor behavior** - a sign and/or a symptom occurring in Schizophrenia that is observed as a marked decrease in reactivity to the environment, a complete lack of responsiveness, the assumption of inappropriate and/or bizarre positions and/or purposeless activity

**catalepsy** - a mental state in which a person’s muscles are partly rigid

**cataplexy** – brief episodes or attacks consisting of the loss of muscle tone leading to collapse and or immobility and a state resembling REM sleep without a loss of consciousness that may be due to an intense emotion

**circadian sleep-wake pattern** - the systematic repetitive and endogenous or normal pattern of sleep and wakefulness that occurs during a 24 hour period - the regular biologically based rhythmic repetitive periods of sleep and wakefulness that occur in a given individual in a 24 hour period – this is also called a diurnal rhythm or a biological clock

**clinical scales** - groups of questions on objective psychological tests such as the Minnesota Multiphasic Personality Inventory (MMPI) that yield scores that are capable of providing information about a person’s personality traits and/or psychopathology

**compulsions** - repetitive patterns of behavior in the form of rituals, such as cleaning, ordering, checking, counting, or repeating words silently, aimed at reducing anxiety as compared to providing pleasure

**constant symptoms** - symptoms that occur 90 to 100% of the time
**constricted affect** - a contracted or limited range of observable behavior or signs indicative of an individual’s subjective feelings or mood

**cross-gender identification** - the desire to be a member of the opposite gender or an insistence that one is actually a member of the opposite gender

**deferred diagnosis** - a DSM-IV-TR diagnosis statement that is made when the doctor has “Information inadequate to make any diagnostic judgment” about an Axis I diagnosis or condition or an Axis II diagnosis

**delirium** - a disturbance in consciousness such as a reduction in the clarity of one’s awareness of the world around them that is accompanied by a reduced ability to attend to events

**delusions** – beliefs maintained in the presence of overwhelming evidence contrary to those beliefs

**delusions of reference** - delusional beliefs that certain people, events, or things in one’s environment have a special significance

**dementia** - multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances: aphasia or a language impairment, apraxia or a deficit in performing purposeful body movements, agnosia or an impairment in the ability to recognize familiar objects, or a disturbance in executive functioning

**depersonalization** - a feeling of being detached from oneself

**derealization** - a feeling of unreality

**disability** - in DSM-IV-TR terminology this is defined as an impairment in one or more areas of functioning – in legal circumstances the definition may be different than DSM-IV-TR terminology and may vary by jurisdiction
**disorganized speech** - as seen in Schizophrenia this is shown by incoherence and/or “derailment,” a tendency for ideas to “slide” from one “track” onto an unrelated or an indirectly related “track”

**disorganized thinking** - as seen in Schizophrenia this is observed in disorganized speech that does not make any sense in the context of the conversation and at times may be totally incomprehensible

**dissociative amnesia** - a loss of memory, usually for important recent events, that is thought to occur as a result of a traumatic environmental event

**dissociative signs and/or symptoms** - as seen in dissociative amnesia, these are behaviors, feelings and/or thoughts in which there is a total or partial disconnection between one’s memories, motivations, feelings, thoughts and behaviors

**distress** - a painful sign and/or symptom

**echolalia** - parrot-like repetition of overheard words and/or fragments of speech often delivered or spoken with a mocking intonation

**echopraxia** - seemingly automatic or uncontrollable imitation of the movements of other people

**ego-dystonic** - something an individual experiences as self-repugnant, alien, discordant and/or inconsistent with one’s personality

**elevated mood** - a heightened mood that is characterized by feelings of euphoria, elation and well-being

**empathy** - the ability to understand another person’s state of mind, including their thoughts and feelings, and the ability to experience those thoughts and feelings from the other person’s point of view

**endogenous** - originating from within

**exacerbation** - an increase in the signs and/or symptoms of a physical or psychiatric disorder
**exaggerated startle response** - an overreaction to a sudden and unexpected occurrence such as a loud noise

**examination** - this refers to all of the procedures employed in a psychological evaluation from the time the patient walks in the door until they leave the office for the last time - see also “interview”

**evaluation** - a term synonymous with “examination”

**exogenous** - originating from outside of the person

**expansive mood** - a mood that is characterized by unrestrained emotional expression and often accompanied by an overvaluation of one’s importance or significance to others

**fibromyalgia** - a disorder characterized by chronic widespread pain

**flashback** - the experience of reliving an experience from one’s past

**flight of ideas** - a continuous flow of accelerated speech with abrupt transitions from topic to topic, usually without transitions, which is based on arbitrary conceptual or verbal links not easily discernible by the listener

**flattened affect** - a lack of emotional expressiveness that is observable in unchanging and unresponsive facial expressions, an unmodulated speaking voice, an avoidance of eye contact and a restriction of expressiveness in body movements

**general medical condition** – a physical disorder or condition - conditions and disorders not listed in the “Mental and Behavioral Disorders” chapter of the guidebook of mental and physical disorders called the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD) that is published by the World Health Organization

**grandiosity** - a sense of inflated self-esteem

**grimacing** - contorted or “ugly” facial expressions
**glossy disorganized behavior** - as seen in Schizophrenia it is observed in a variety of ways such as childlike silliness, unpredictable agitation and difficulty performing normal activities of daily life such as maintaining personal hygiene

**Huntington’s disease** - a rare genetic disease characterized by chronic and progressive mental deterioration ending in dementia

**hypervigilance** - a state of exaggerated oversensitivity to a class of events the purpose of which is to detect threats

**hypnagogic hallucinations** - intense or vivid dreamlike images that occur just before falling asleep

**hypnopompic hallucinations** - intense or vivid dreamlike images that occur shortly after awakening

**hypoxophilia** - a type Sexual Masochism that requires oxygen deprivation by, for example, the use of a noose or a plastic bag to produce a decrease in brain oxygenation that results in an enhanced sexual excitation – when this procedure leads to inadvertent death it is called auto-erotic asphyxia

**ideas of reference** - a pattern of believing that external events and activities have a special significance for the person

**internally inconsistent** - when data within any source or group of sources of information reveal inconsistencies, those data are said to be internally inconsistent

**interview** - a face-to-face meeting between an interviewer and an interviewee

**locus of control** - a personality trait or dimension on which people vary on the extent to which they believe that the control of their life is under forces within themselves as compared to being under the control of forces outside themselves
**Manic-Depressive Illness** - the former name of a group of Mood Disorders now called Bipolar Disorders that are characterized by major changes in mood over time

**mental disorder** - a psychological disorder - in DSM-IV-TR terminology this is defined as “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.” - additionally the DSM-IV-TR makes it clear that the “syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event”

**Mental Status Examination** - an examination conducted by a mental health worker that produces a set of observations that were collected under reasonably controlled conditions employing a relatively standard set of examining techniques and questions and provides an overall picture of the individual’s mental or psychological status in a wide variety of areas

**modifiers** - in DSM-IV-TR terminology these are terms that can be applied to mental or psychological disorders that indicate their severity or the possibility that the individual has had the disorder in the past and has either recovered completely or partially or still has some signs and/or symptoms of the disorder - modifiers are sometimes called diagnostic specifiers

**mood** - a sustained emotion as experienced by the person (contrast with “affect”)

**myotonic dystrophy** - a chronic and slowly progressing multi-system disorder that is characterized by a wasting away of the muscles

**negative signs and/or symptoms** - as seen in Schizophrenia it is observed as flattened affect; alogia or impoverishment of thought and/or speech; and/or avolition or an inability to initiate or sustain purposeful activities
**nonrestorative sleep** - sleep that is perceived by the individual as characterized by restlessness, “lightness,” and/or of poor quality - such individuals typically do not feel refreshed upon awakening but complain about feeling tired, lacking concentration, irritability and poor work performances despite having had enough sleeping time

**normal depression** - a person can be depressed but not suffering from a Depressive Disorder if their depression is normal, reasonable, understandable and expectable for what they have experienced, such as the death of a loved one or a traumatic physical injury - as noted in the DSM-IV-TR, “sadness” is part of the human condition and “periods of sadness are inherent aspects of the human experience”

**obsessions** – as defined by the DSM-IV-TR these are “persistent ideas, thoughts, impulses and/or images that are experienced as intrusive and inappropriate and cause marked anxiety and/or distress”

**Obstructive Sleep Apnea Syndrome** - a pattern of signs and/or symptoms that constitute the most common category of sleep-disordered breathing and is characterized by repeated episodes of upper airway obstruction during sleep that are due to the collapse of the walls of soft tissue in the airway at the level of the throat

**Parkinson’s disease** - a degenerative disorder of the central nervous system that typically results in an impairment of the individual’s motor skills and speech

**partial disability** - a type of physical or psychological disability in which the individual is not completely incapacitated but can engage in their normal and customary activities although with some loss of function

**permanent disability** - a type of physical or psychological disability in the person’s ability to perform their normal and customary activities that has stabilized and will not change

**Pervasive Developmental Disorder** - a severe and extensive impairment in the development of social and communication skills, or the presence of stereotyped behaviors, interests or activities
physical intersex condition – a condition that is also called hermaphroditism and is characterized by an individual having both male and female sexual organs, usually with one gender dominating

postmenarcheal - after the first menstrual period

Prader-Willi Syndrome - a very rare genetic disorder that expresses itself in learning difficulties, a pre-occupation with food, excessive hunger and a large food intake

pressure of speech - continuous, excessive, loud, rapid and sometimes incoherent speech that is difficult for the listener to interrupt and may continue even when no one is listening

prodromal - signs that are precursors of an actual Schizophrenic episode and present as relatively mild or subthreshold forms of delusions, hallucinations and/or disorganized behavior

provisional diagnoses - diagnoses given when there is a strong presumption that the criteria for diagnosing a disorder will eventually be met, but that at the time of examination not enough information was available to make a firm diagnosis

psychological autopsy - a comprehensive psychological evaluation of a person who is deceased that is conducted for the expressed purpose of determining if they had a psychological disorder, disability or injury

psychological disorder - a mental disorder - in DSM-IV-TR terminology this is defined as “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom” - additionally the DSM-IV-TR makes it clear that in order to diagnose a disorder correctly the “syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event”
**psychological injury**  - a psychological injury is said to have occurred when some event has produced a psychological disorder

**psychomotor agitation**  - excessive motor activity that usually is exhibited as purposeless behavior, such as pacing, and is accompanied by feelings of anxiety or tension

**psychosocial stressor**  - a life event that produces strain or tension that is difficult to endure or manage

**psychomotor retardation**  - a general slowing of body movements

**REM sleep**  - rapid-eye-movement sleep - a sleep stage that occurs in progressively lengthening episodes roughly every 90 minutes throughout the night, and typically accounts for about 20% of sleeping time and is strongly associated with vivid dreams and a characteristic pattern of brain waves

**residual signs**  - as applied to Schizophrenia, residual signs are relative mild or subthreshold forms of delusions, hallucinations, and/or disorganized behavior that follow an active phase of the illness

**rule-out diagnosis**  - a diagnostic statement indicating that the doctor wishes to eliminate or exclude the possibility of a specific named disorder but has not yet done so

**sign**  - an observable segment of behavior that may be indicative of a disorder

**specifiers**  - in DSM-IV-TR terminology these are terms that can be applied to mental or psychological disorders that indicate their severity or the possibility that the individual has had the disorder in the past and has either recovered completely or partially or still has some signs and/or symptoms of the disorder - specifiers are sometimes called diagnostic modifiers
**startle response** - a reflexive reaction to a sudden, intense and unexpected occurrence such as a flash of light, a loud noise or a quick movement that includes physical movement away from the stimulus, a contraction of the muscles of the extremities, blinking and physiological changes in blood pressure and breathing – see exaggerated startle response

**stereotyped movements** - as seen in Schizophrenia, Catatonic Type stereotyped movements are repetitive, non-functional, self-injurious bodily movements such as body rocking, head banging and self-biting

**stressor** - see psychosocial stressor

**stupor** - a state of lethargy or unresponsiveness

**Substance Intoxication** - the development of a set of specific and reversible behaviors due to the ingestion or exposure to a substance that by DSM-IV-TR definition causes maladaptive behavioral changes during or shortly after using the substance

**Substance Withdrawal** - the development of a set of specific maladaptive behaviors with possible physiological findings and cognitive impairments that is due to either the cessation or reduction in the use of a substance and that cause distress and/or impairment

**suicidal gesture** - an action that on the surface looks like an attempt to take one’s life but does not end in death as a result of the person not being fully committed to taking their life

**symptom** – a patient’s complaint that may be indicative of a disorder

**syndrome** – a set of signs and/or symptoms that occur together and appear to be indicative of a disorder

**temporary disability** - a type of physical or psychiatric disability that restricts a person’s ability to perform their normal and customary functions and is temporary in the sense that the person has not reached a plateau or a permanent level of disability but instead can be reasonably expected to improve
**total disability** - a type of physical or psychological disability in which an individual is completely incapacitated from performing their normal activities

**validity scales** - groups of questions on objective psychological tests that yield scores that are capable of determining if the person taking the test has responded in an honest and frank manner

**“vs.” diagnosis** - a diagnosis expressing uncertainty about which of two possible diagnoses should be made

**worry** - apprehensive expectations
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