

# THE WETC PSYCHOLOGY NEWSLETTER

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"Find the Truth, Tell the Story"

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## Cross Examining Shrinks: Leckart's Fifth Rule

In the last four months I have provided a discussion of Leckart's first four rules for cross-examining psychologists and psychiatrists. Essentially, they are: (1) never ask the doctor about the patient but confine your questions to the doctor's report, (2) focus your questions on the doctor's diagnosis, (3) determine if the doctor has taken a complete history of the patient's symptoms or complaints that supports their diagnosis, and, (4) always determine if the doctor has presented a credible patient history.

**Leckart's Fifth Rule states that the attorney should always determine if the doctor has provided a credible report of their Mental Status Examination that supports their diagnosis.**

In order to follow Leckart's Fifth Rule it is necessary to consider the nature of a Mental Status Examination. Essentially, a Mental Status Examination (MSE) provides a set of observations of the patient that are made by the doctor employing a relatively standard set of examining techniques and questions. You can read more about the nature of Mental Status Examinations by going to my website at [www.DrLeckartWETC.com](http://www.DrLeckartWETC.com) and reading my newsletters Number 19 and 27 or the portions of my book that deal with the subject (Psychological Evaluations in Litigation: A Practical Guide for Attorneys and Insurance Adjusters). If you get really serious about learning about these examinations I can recommend two classic books: Strub, R.L. & Black, F.W. The Mental Status Examination in Neurology, Fourth Edition. Philadelphia,

Browse Dr. Leckart's Book,  
**Psychological Evaluations in  
Litigation: A Practical Guide for  
Attorneys and Insurance Adjusters**  
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*When a psych doctor's report is not in your favor and you wish to challenge their conclusions, all you need is a report of the flaws in that document as well as a list of questions to ask the doctor that will expose those problems.*

Pa.: F. A. Davis, 1999, and, Trzepacz, P.T. & Baker, R.W. The Psychiatric Mental Status Examination. New York: Oxford University Press, 1993.

While the number of sets of data that comprise a Mental Status Examination are somewhat arbitrary most experts would agree that the following is a reasonable description of what should be found in the doctor's discussion of their direct observations of the patient's behavior. These are the patient's:

1. appearance including orientation, historical ability, speech, and locomotion
2. credibility with comments and information about the presence or absence of evasiveness, vagueness and inconsistencies
3. emotional reaction on meeting the examiner including their general behaviors
4. mood
5. short-term, intermediate and long-term memory
6. attention and concentration
7. thought and functional processes such as judgment, reasoning, insight and linguistic skills
8. ability to function in the examination situation
9. social behaviors during the examination
10. presence or absence of severe psychopathological behaviors

Now the key question that must be asked about the contents of a doctor's Mental Status Examination is, "Do the data found in their report support the diagnosis"? If they do

not, then the doctor's diagnosis and all of the conclusions that stem from that diagnosis, such as those about causation, disability, and the need for treatment suddenly become irrelevant.

As with all of the other Leckart Rules I have written about, the key to questioning a doctor during a deposition is the doctor's diagnosis and the definition of that diagnosis that appears in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). The most recent version that has been generally accepted by the mental health community is the fourth revised edition that is referred to as the DSM-IV-TR.

Here is how to proceed in questioning the doctor. It is conceptually quite simple. First get the doctor's diagnosis. Second, get a copy of the diagnostic criteria found in the DSM-IV-TR. Third, create a set of questions to determine if the doctor has provided sufficient observational data in their report of their Mental Status Examination to support their diagnosis. That's it!

Let's see how this is done for just one disorder, a Major Depressive Disorder.

A reading of the DSM-IV-TR indicates that the nine possible symptoms of a Major Depressive Disorder are:

1. Depressed mood, most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss or weight gain when not dieting or a decrease or increase in appetite, nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day.
6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.

A reading of the above diagnostic criteria reveals that some of the criteria will probably not be directly observable during the course of a face-to-face Mental Status Examination. Obviously, there is no way to observe if the patient has insomnia or hypersomnia. Those data will have to come from the patient's history and/or their medical records. However, to cite just one example of behavior that can be observed, "What evidence is there in the doctor's Mental Status Examination indicating that the patient had a depressed mood"?

During a face-to-face clinical interview, people who are clinically depressed often present with narrative themes of worthlessness, helplessness, hopelessness, self-reproach, guilt, pessimism, failure, incompetence, a loss of interest in pleasure, difficulty thinking, difficulty making simple decisions, demoralization and thoughts of death and/or suicide. Behaviorally, they often appear with psychomotor retardation or agitation, reduced cognitive functioning, deficits in attention, memory problems, sadness, tearfulness, looking as if they are about to cry, irritability, indecisiveness and social withdrawal. What has the doctor said that reveals that they observed these common characteristics of a clinical depression? The key to cross-examining the doctor about their Mental Status Examination is to simply read their report, note if they observed any of the above-mentioned signs and if they haven't simply ask the doctor where in their report they recorded observations they made indicating that the patient had presented with behaviors indicative of a clinical depression. Of course, the worst reports are those in which the doctor summarily stated that the patient observed was "depressed" but the doctor never stated what specific observations led them to that conclusion.

Besides the absence of specific Mental Status Examination behavioral observations supporting their diagnosis many doctors provide reports of their Mental

### Pre-deposition consults involving reports of an

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for more information)

Status Examination that contain additional flaws, which can be exposed on cross-examination that will challenge the credibility of their reports. Here's a list:

The presentation of summary conclusions with no supporting data. For example, the doctor might state that the patient presented with a deficient memory but when reading their report you find that they did not provide the data they collected using standard examining techniques, if they actually collected any data, demonstrating that there was a problem with the patient's memory.

Presenting the patient's complaints as evidence of psychopathology when the report of a Mental Status Examination is reserved for the doctor's observations, not the patient's complaints. For example, the doctor might state that the patient told them they were depressed most of the day, nearly all day long. This is a complaint or a symptom, not an observation made during the face-to-face examination and has no place in a doctor's report of their Mental Status Examination.

The failure to measure some of the required mental status processes. For example, during the course of a Mental Status Examination the doctor typically provides information about the patient's ability to use their thought processes. One way of doing this is to ask them to interpret proverbs such as, "The squeaky wheel gets the grease." If there are no data addressing this issue then the doctor's report of their Mental Status Examination is substantially flawed. There may be a lack of support for their diagnosis, if they diagnosed a disorder that has disturbed thought processes and no data supporting any such disturbance were presented.

Another major problem is inconsistencies between the doctor's report of their Mental Status Examination and the patient's complaints. One such frequent error concerns the patient's complaints of memory and concentration problems. Specifically, a flawed psychological or psychiatric report often states that the patient complained about both memory and concentration problems yet when one reads the doctor's report of their Mental Status Examination there are no data speaking to the patient's memory and concentration, or worse yet, the doctor has reported normal memory and concentration processes. Generally, when this occurs the doctor never points out the inconsistency between their data and the patient's complaints, another fatal flaw.

Another significant problem is that some doctors actually never administer a Mental Status Examination but simply give the patient a checklist to describe the

functions normally measured by the doctor during their face-to-face interview. Obviously, asking the patient to provide their own Mental Status Examination is a "no-no."

Yet another frequent significant flaw occurs when the doctor obtains psychological testing data that is inconsistent with the Mental Status Examination data. For example, the doctor might report that results from their Mental Status Examination revealed data indicating that the patient had no problems with their memory, concentration, thinking, judgment, reasoning and insight. However, when their report is read one finds psychological testing data that is inconsistent with the doctor's Mental Status Examination data. This situation only becomes worse when the doctor has provided no explanation of this inconsistency.

And probably the absolute worst flaw is the doctor who simply never administers a Mental Status Examination but writes two or three sentences buried somewhere in their report claiming that the patient's mental status processes were normal, abnormal or somewhere in between, with no data supporting those naked assertions.

In summary, Leckart's Fifth Rule states that on cross-examining a psychologist or psychiatrist the attorney should always determine if the doctor has provided a credible report of their Mental Status Examination that supports their diagnosis. The key is to obtain the DSM-IV-TR diagnostic criteria for the disorder, determine if the Mental Status Examination is consistent with the doctor's diagnosis and if there is no or little consistency, ask questions that point out that the doctor has provided no Mental Status Examination support for their diagnosis, thereby questioning the credibility of that diagnosis as well as all of the other conclusions which depend on that diagnosis.

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This is the seventy-second of a series of monthly newsletters aimed at providing information about psychological evaluations and treatment that may be of interest to attorneys and insurance adjusters working in the areas of workers' compensation and personal injury. If you have not received some or all of our past newsletters listed on the next page, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.