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ACTUAL REPORT: ALL NAMES HAVE BEEN FICTIONALIZED

January 3, 2013

Mr. Robert Carol
Michel, Terrel, Carol & Tom, LLP
3696 Lucks Parkway, Suite 360
Irvine, California 92618

Re:	Laura Amahl v. Bates
D/I:	January 13, 2010
Client:	Dina Bates
File No.:	030-011

EXPEDITED CONFIDENTIAL DOCTOR-ATTORNEY PRIVILEGED PRELIMINARY REPORT
RE: EXPERT WITNESS TESTIMONY

Dear Mr. Carol:

As per your request of January 2, 2013, I have reviewed a variety of medical records concerning Ms. Laura Amahl in conjunction with her personal injury litigation naming Ms. Dina Bates as the defendant. In particular, it is my understanding that you are interested in the credibility of the diagnosis and conclusions, both stated and implied, made by Dr. Maryann S. Kershaw a Marriage and Family Therapist (MFT#65325) in her report of October 30, 2012 and her treatment or case notes that purportedly reflect the contents of 68 "Individual Psychotherapy" sessions or other noted entrees. In this regard,

I understand that you are scheduled to take Dr. Kershaw's deposition testimony on January 4, 2013. It is also my understanding that at some time you may ask me to provide expert witness testimony in Ms. Amahl's case at either a deposition or in a courtroom. Having reviewed all of these records, I am writing with my comments. It is my belief that this document will not be subject to discovery as you are asserting privilege over this assignment, which is protected under the attorney client privilege and work product doctrines. It is also my belief that you may use some or all of the information in this report for other purposes in defending against Ms. Amahl's litigation.

GENERAL APPROACH TO THE PROBLEM

As noted above, it is my understanding that your main concern in referring this case to me is the credibility of the conclusions appearing in the October 30, 2012 report issued by Dr. Maryann S. Kershaw, a Marriage and Family Therapist as well as those in her treatment or case notes. In regard to those documents, my general approach to providing information about the credibility of psychological and psychiatric reports involves understanding that the keystone of any such report is the doctor's diagnoses. Specifically, in the absence of one or more credible DSM-IV-TR diagnoses, it is not reasonable to conclude that a plaintiff has had a psychiatric injury. As we shall see, this is the case with Dr. Kershaw's report and notes concerning Ms. Amahl. Thus, since it is not reasonable to conclude that Ms. Amahl has had either a psychological disorder or a psychiatric injury as a result of the motor vehicle accident of January 13, 2010, it is also not reasonable to conclude that she has suffered a psychiatric injury or a psychiatric disability as a result of that incident or any other factors in her life, or has been in need of psychological or psychiatric care on any basis whatsoever. Specifically, as we shall see, there are sufficient data to conclude that Dr. Kershaw's report and notes are substantially flawed with regard to her diagnostic conclusions and, therefore, her and anyone else's assertion that Ms. Amahl has had a psychiatric injury as a result of the motor vehicle accident of January 13, 2010 is not credible.

In approaching Dr. Kershaw's deposition testimony I recommend that you keep foremost in your mind that DSM-IV-TR diagnoses are empirically defined in that diagnostic manual. As such, there is very little ambiguity in the diagnostic criteria in the DSM-IV-TR or the manner in which they are to be applied. Thus, the credibility of any psychological or psychiatric report rests on the correlation between the doctor's data and the diagnostic criteria. If there are insufficient data in the doctor's report demonstrating that the patient has met the specific diagnostic DSM-IV-TR criteria then it follows that the diagnosis is not supported. When this occurs, the doctor's diagnosis must be discounted and all of the conclusions resting on that diagnosis are unsupportable. In short, without a credible diagnosis none of the doctor's other opinions are relevant.

Finally, I would also like you to consider the following "rule" in taking Dr. Kershaw's deposition. Never ask the doctor about the plaintiff! I strongly recommend that all the questions you ask be directed at the doctor's report. For example, instead of asking Dr. Kershaw to describe what she observed that led her to conclude that Ms. Amahl was suffering from a psychological disorder, it is much better to ask her where in her report you can find the data indicating that she made sufficient observations of Ms. Amahl to warrant a diagnosis. The reason for this is quite simple. If you ask the doctor about the plaintiff they can feel free to provide information not in their report that may justify some of their conclusions. Obviously, that information may or may not be correct for a variety of reasons. However, if you confine your questions to what is in the report, no new "evidence" can find its way into the testimony. In this regard, at the end of this report you will find some suggestions for questions to be asked at the deposition that will reveal the many flaws found in Dr. Kershaw's report of October 30, 2012. However, if you decide to use a large number or all of these questions I would anticipate that the deposition would take longer than one hour and you should plan for that occurrence. Of course, you may wish to select only a portion of the questions, or modify them in a manner that suits your style, which could allow for a single hour of testimony.

REVIEW OF MEDICAL RECORDS

Review of the October 30, 2010 Report

On October 30, 2010, Dr. Maryann S. Kershaw, a Marriage and Family Therapist, submitted a 2-page report. In that report she summarized her impressions of Ms. Amahl history, her presenting complaints and her clinical presentation as of Dr. Kershaw's most recent contact with Ms. Amahl, which she stated was September 27, 2012. On page 2 of that report, she diagnosed a "PTSD," which is an abbreviation for a Posttraumatic Stress Disorder (309.81). That disorder is found in the American Psychiatric Association's diagnostic manual, the DSM-IV-TR, the full name of which is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). Additionally, an inspection of bills from Dr. Kershaw's office dated August 19, 2011 and February 22, 2012 reveals that she billed for 56 "Individual Psychotherapy" sessions, all of which were for treatment of the diagnostic code 309.81, indicating that at no time between the sessions that occurred between January 12, 2011 and February 14, 2012 did her diagnosis change. These billing records appear to be incomplete as Dr. Kershaw's treatment notes indicate she first met with Ms. Amahl on September 21, 2010 and last met with Ms. Amahl on September 27, 2012. A reading of those treatment notes indicates that Dr. Kershaw had at least 65 "Individual Psychotherapy" sessions as three of her entrees dated reflect other activities. Specifically, on October 2, 2010 Dr. Kershaw noted she made a telephone call to an unnamed neurologist. Additionally, her entrees of April 16, 2012 and April 17, 2012 reflect her and Ms. Amahl's attendance at Ms. Amahl's deposition although there also were some notes on those dates reflecting what might have been psychotherapeutic endeavors.

Before proceeding to consider the credibility of Dr. Kershaw's diagnosis, it is relevant to consider the nature of her professional contact with Ms. Amahl. As noted above, Ms. Amahl was reportedly being treated for a Posttraumatic Stress Disorder. In this regard, it should be considered that a reading of Dr. Kershaw's case or treatment notes indicates that on a variety of occasions Ms. Amahl's parent's, boyfriend and sisters were, at least in part, subjects of discussion during the meetings between Dr. Kershaw and Ms. Amahl. This is as would be expected from considering Dr. Kershaw's licensure as a

Marriage and Family Therapist. In this regard, it should be noted that during the period prior to February 13, 2012, when Dr. Kershaw was treating Ms. Amahl, section 4980.02 of the Business and Professions Code of California defined Marriage, Family, and Child Counseling (MFCC) by stating:

> "For the purposes of this chapter, the practice of marriage, family, and child counseling shall mean that service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and premarriage counseling.
>
> The applications of marriage, family and child counseling principles and methods includes, but is not limited to, the use of applied psychotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, and the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships."

In this regard, on February 13, 2012 the Business and Professions Code of California Section 4980.02 was changed to define the practice of Marriage and Family Therapy as:

> "For the purposes of this chapter, the practice of marriage and family therapy shall mean that service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and premarriage counseling. The application of marriage and family therapy principles and methods includes, but is not limited to, the use of applied psychotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships, and the use, application, and integration of the coursework and training required by Sections 4980.36, 4980.37, and 4980.41, as applicable."

A reading of both sections appears to indicate that counseling or administering psychotherapy or any other "applied psychotherapeutic techniques" to alleviate and/or cure a Posttraumatic Stress Disorder seems to be outside of the realm of the licensure of a Marriage and Family Therapist (MFT), or what used to be called a Marriage, Family and Child Counselor (MFCC). As such, the credibility of Dr. Kershaw's reporting, as well as the necessity for her "treatment" or "Individual Psychotherapy," does not appear to fall under her license as a Marriage and Family Therapist.

The above discussion notwithstanding, an inspection of Dr. Kershaw's report and her treatment notes indicates that there are insufficient data in those documents to indicate that Ms. Amahl has ever had a Posttraumatic Stress Disorder or any other disorder found in the DSM-IV-TR. Accordingly, her report and notes are 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 factors. These data are discussed below.

DSM-IV-TR psychiatric diagnoses are made after considering as many as five different sources of information. These sources of information are: 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 that are available at the time of diagnosis. An examination of Dr. Kershaw's report indicates that when all five potential sources of information are considered, there is no support for the diagnosis of a 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. Additionally, they are presented in Appendix A, which is a copy of page 468 taken from the DSM-IV-TR, which can be used during a deposition of Dr. Kershaw.

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.

A reading of Ms. Amahl medical records from the California Highway Patrol, the Upland Fire Department, Mercy Air Services the Emergency Room at the Arrowhead Regional Medical Center, as well as the medical records of Dr. Paulina Samsih Himtil, a neurologist, Dr. Jaime B. Ariel, an orthopedist, Dr. Awal Goath, a neurological surgeon, Dr. Thomas A. Chey, a neurologist and documents from a variety of other health professionals leaves little doubt that Ms. Amahl has been exposed to "an event in which there was an actual or threatened death or serious injury to him or herself or others." However, and most importantly, there are no data in Dr. Kershaw's records indicating that Ms. Amahl has ever met any of the other criteria needed to diagnose a Posttraumatic Stress Disorder correctly.

First, with regard to the life history and presenting complaints reported by Dr. Kershaw, her brief report presents no history of Ms. Amahl's prior life to use as a baseline for comparison with what Dr. Kershaw stated was her current psychological status. Other than some extremely vague references to Ms. Amahl's family, "rock climbing" and having been a graduate of "Berkley" the reader of Dr. Kershaw's report knows nothing about Ms. Amahl's life prior to her initial contact with Dr. Kershaw. We also know nothing about Ms. Amahl's life subsequent to February 14, 2012 when she reportedly "left her home city of San Francisco and moved to a small town in New Mexico," whose name was not identified. We also do not know if Dr. Kershaw's reference to "Individual Psychotherapy" sessions is based on face-to-face contact with Ms. Amahl versus telephone or Internet contact. The latter possibility is suggested by Dr. Kershaw's stationery, which indicates that her office is located in Newport Beach, California and her reference to Ms. Amahl leaving San Francisco on or about February 14, 2012. In short, we know almost nothing about Ms. Amahl or her life prior to or subsequent to January 13, 2010, information

that is most assuredly needed to completely assess Ms. Amahl's psychological status and any problems that she might have presented with to Dr. Kershaw.

Additionally, with regard to Ms. Amahl's presenting complaints or, as they are sometimes called, symptoms the reader of Dr. Kershaw's report is almost completely in the dark. Generally, in order to diagnose a DSM-IV-TR disorder correctly it is necessary to have information about the qualitative nature of the patient's symptoms or complaints as well as specific information about the frequency, intensity, duration, onset and course of those symptoms over time. Clearly, when it comes time to providing a comprehensive history of Ms. Amahl all we can gain from Dr. Kershaw's report is her depiction of Ms. Amahl as having a variety of summarily provided complaints such as "depression," "overstressing her brain," "memory impairment," "agoraphobia," and "time-sense disorientation." Additionally, even if the reader knew what Dr. Kershaw was referring to in this and other examples, we would still not have sufficient information to support the diagnosis of a Posttraumatic Stress Disorder. Overall, the essential question that must be dealt with is, "Has Dr. Kershaw provided sufficient data in her report indicating that Ms. Amahl had sufficient complaints to warrant the correct diagnosis of a Posttraumatic Stress Disorder as defined by the DSM-IV-TR?" In this regard, when the complaints attributed to Ms. Amahl by Dr. Kershaw are examined, it is found that those complaints are insufficient to warrant the correct diagnosis of a Posttraumatic Stress Disorder. This is a substantial flaw in Dr. Kershaw's report and notes and, if she were a psychologist or a psychiatrist, this would be a violation of professional standards in both of those professions for the preparation of reports for the court.

Second, a further reading of Dr. Kershaw's report reveals no evidence indicating that she ever gave Ms. Amahl a Mental Status Examination. In this regard, it should be understood that a Mental Status Examination is a part of every psychological or psychiatric evaluation. Additionally, a Mental Status Examination produces a set of observations of the patient, which are made by the doctor, under reasonably controlled conditions using a relatively standard set of examining techniques and questions. Unfortunately, a reading of Dr. Kershaw's report provides no information about Ms. Amahl's performances on a variety of tests that could confirm and

quantify some of the complaints or symptoms attributed to Ms. Amahl. For example, in her report Dr. Kershaw asserted that Ms. Amahl had "severe anxiety," a "lack of ability to concentrate, a "short-term memory impairment," and "depression." All of these factors are either easily measured during the course of a Mental Status Examination with a battery of objective techniques that yield easily reported upon data or are directly observable in multiple ways.

In regard to the above, just one measure of concentration involves asking an individual to perform a serial 7's task, which requires them to count backwards from 100 by 7's. Similarly, short-term memory is measured by asking an individual to recall multiple series of digits that vary in length. For example, the doctor can give the individual a series of numbers, such as 8-6-2-0-4-1, at one-second intervals and then ask them to recall the entire series in the sequence in which it was given. Further, during a face-to-face contact depression is observable in a variety of ways. For example, patients who are clinically depressed may 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, sadness, tearfulness, looking as if they are about to cry, irritability, indecisiveness and social withdrawal. Further, patients who are pathologically anxious are commonly observed to express unrealistic fears and/or worries and typically present with themes in their narrative of danger, threat, unpredictability, uncertainty and/or terror and often complain of a variety of physical symptoms including shortness of breath, heart palpitations, chest tightness or pain, rapid heartbeats, sensations of choking and/or smothering, dizziness, diarrhea, frequent urination, tingling sensations in the extremities, light headedness, cold sweats, hot flashes, dry mouth, shaking, jitteriness, and/or trembling. On direct observation their behavior is often characterized by jumpiness, restlessness, hand wringing, a strained voice, tremulousness, tension, motor hyperactivity, fidgeting, autonomic hyperactivity, vigilance, scanning and/or poor reality testing. With regard to phobic avoidance this is observed as a marked and/or persistent fear that is excessive or unreasonable and occurs in a specific

environmental situation. If Dr. Kershaw observed these signs during a face-to-face Mental Status Examination of Ms. Amahl it is certainly not evident from reading her report of October 30, 2012.

In addition to the above, a reading of Dr. Kershaw's report indicates that she did not describe having given Ms. Amahl any psychological tests. The use of objective psychological testing in a psychological or psychiatric evaluation is highly crucial since objective psychological test data is typically the only form of non-subjective information that can be presented to the court and is open public inspection. Additionally, psychological testing is capable of determining with reasonable medical probability if the person who is claiming psychological dysfunction is credible. Moreover, objective psychological test data is 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 Dr. Kershaw's report and general methodology is most assuredly a substantial flaw. It means that there are absolutely no data that can be reviewed by an independent and impartial observer that could provide information about Ms. Amahl's psychological status at any point in time. Viewed in this light, all of the remaining statements in Dr. Kershaw's report and notes are completely subjective.

Another source of valuable data in arriving and supporting a DSM-IV-TR diagnosis is the patient's medical records. In this regard, a reading of Dr. Kershaw's report or notes reveals no evidence that she reviewed any of Ms. Amahl's medical records. Further, Dr. Kershaw did not report on having any collateral sources of information in the form of interview data collected from any of Ms. Amahl's friends, relatives and/or co-workers that could support any of her conclusions. Nevertheless, the absence of medical record data and collateral sources of information is not a particularly crucial or unusual finding. However, what is crucial and unusual is the absence of a complete history of the patient's current complaints to support the Dr. Kershaw's diagnosis and conclusions, the absence of Mental Status Examination observational data supporting Dr. Kershaw's diagnosis and conclusions and the absence of objective psychological testing data supporting her opinions. These flaws in the Dr. Kershaw's report and associated records indicate that there are no data whatsoever indicating that Dr. Kershaw found

Ms. Amahl to be suffering from a Posttraumatic Stress Disorder. There were also no data indicating that 65 "Individual Psychotherapy" sessions were needed to cure or alleviate that disorder. Overall, Dr. Kershaw's report contains substantial flaws that have left it without credibility and completely incapable of proving or disproving a disputed medical fact or a contested claim.

In summary, for all of the reasons given above, there is no support in Dr. Kershaw's report for her diagnosis of a Posttraumatic Stress Disorder. Quite clearly, this represents a substantial flaw in that document, as well as a violation of community standards in psychology and psychiatry for the evaluation of plaintiff's in personal injury litigation and the preparation of reports for the court.

SUMMARY AND CONCLUSIONS

As noted in my introductory remarks, your main reason for referring this case to me is the credibility of the October 30, 2010 report and the case or treatment notes issued by Dr. Maryann S. Kershaw, a Marriage and Family Therapist. Clearly, as I noted above, it should be understood that the keystone of any psychological report is the psychological diagnoses. In this regard, in the absence of one or more credible diagnostic conclusions, it is not reasonable to conclude that a plaintiff has had a psychiatric injury as a result of any of a variety of events such as a motor vehicle accident, a slip and fall or even a dog bite. Moreover, without at least a single credible diagnosis, it is not reasonable to conclude that a plaintiff has had any form of a psychiatric disability or has been in need of any psychological or psychiatric treatment on any basis at any point in time.

In regard to the above-mentioned factors, a reading of the Kershaw report of October 30, 2010, as well as her billing records reveals that she diagnosed a Posttraumatic Stress Disorder (309.81) and reported that Ms. Amahl had a variety of symptoms or complaints over an extended period of time. However, when the information in her report and records are examined, there are no historical data in the form of presenting

symptoms or complaints, no face-to-face Mental Status Examination observational data, no psychological testing data, no medical record data and no collateral sources of information that indicate that Ms. Amahl has ever had a psychological disorder. Accordingly, Dr. Kershaw's report and notes are substantially flawed with regard to her diagnostic conclusion as well as her assertion that Ms. Amahl has had a psychiatric injury as a result of the motor vehicle accident of January 13, 2010.

Summary of the Major Flaws in the Kershaw Report of October 30, 2010

1. Dr. Kershaw has diagnosed a Posttraumatic Stress Disorder (309.81) and is licensed as a Marriage and Family Therapist (MFT 37709). However, administering treatment for such a disorder appears to be outside of the scope of her license as indicated by the Business and Professions Code of California section 4980.02.

2. Dr. Kershaw's treatment or case notes discuss no less than 65 "Individual Psychotherapy" sessions that reportedly took place between September 21, 2010 and September 27, 2012. However, on page 2 of her report she stated that Ms. Amahl "left her home city of San Francisco and moved to a small town in New Mexico" on February 14, 2012, leaving the reader to wonder how the psychotherapy took place if Dr. Kershaw's office is in Newport Beach, California and Ms. Amahl was living in San Francisco or New Mexico.

3. Other than some extremely vague references to Ms. Amahl's family, "rock climbing" and having been a graduate of "Berkley" the reader of Dr. Kershaw's report knows nothing about Ms. Amahl's life prior to her initial contact with Dr. Kershaw. More specifically, we have no knowledge whatsoever concerning the possibility of Ms. Amahl having possibly had some psychopathology prior to January 13, 2010. We also know almost nothing about Ms. Amahl's life subsequent to February 14, 2012 when she reportedly left San Francisco and moved to New Mexico.

4. Dr. Kershaw's report and case notes reveals no data indicating that Ms. Amahl has ever met the diagnostic criteria for a Posttraumatic Stress Disorder as that concept is defined by the DSM-IV-TR.

5. There is nothing in Dr. Kershaw's report or her case notes to indicate that Ms. Amahl has ever met any of the diagnostic criteria for a Posttraumatic Stress Disorder except for probably experiencing "an event in which there was an actual or threatened death or serious injury to him or herself or others," as noted in her medical records.

6. With regard to Dr. Kershaw's depiction of Ms. Amahl's symptoms or complaints all the reader has are Dr. Kershaw's summary conclusions. If Dr. Kershaw took a history from Ms. Amahl she did not present any information about the qualitative nature of any of Ms. Amahl's complaints or information about their supposed frequency, intensity, duration, onset or course.

7. There is no indication that Dr. Kershaw ever administered a Mental Status Examination, which produces a set of observations of the patient that are made by the doctor using a relatively standard set of examining techniques and questions. A Mental Status Examination is a standard procedure for a psychological or psychiatric evaluation.

8. There is no indication that Dr. Kershaw ever gave Ms. Amahl any psychological tests, resulting in a situation in which there is no objective public information about Ms. Amahl psychological status at any point in time.

10. There is no indication that Dr. Kershaw had access to any medical records from any mental health professionals who concurred with any of her opinions about Ms. Amahl.

11. There is no indication that Dr. Kershaw had access to any information from any collateral sources of information, in the form of interview data obtained from Ms. Amahl's friends, relative and/or co-workers, who concurred with any of Dr. Kershaw's opinions about Ms. Amahl.

Thank you for the opportunity to participate in this interesting matter. Additionally, after you have examined the contents of this report I would urge you to contact me if you have any questions whatsoever about its contents or would like to discuss any of the issues raised.

Sincerely,

_____

Bruce Leckart, Ph.D.
Qualified Medical Evaluator (914423)
Clinical Psychologist (PSY 4745)
Professor Emeritus of Psychology
San Diego State University

Signed in the County of Los Angeles on _____.

BL:bt

Questions about Dr. Kershaw's report of October 30, 2010 and her treatment or case notes I would not want to be asked if I were Dr. Kershaw.

Dr. Kershaw, I am handing you a copy of the Business and Professions Code of California Section 4980.02 which defines the practice of Marriage and Family Therapy. Will you please tell me how you interpret that section of the code to allow you to treat a DSM-IV-TR mental disorder such as a Posttraumatic Stress Disorder?

Dr. Kershaw, I have obtained from your office a two-page report dated October 30, 2012, two billing statements and a series of treatment or case notes of between 65 and 67 "Individual Psychotherapy" sessions that were dated between September 21, 2010 and September 27, 2012. Are there any other records in Ms. Amahl chart or otherwise in your possession that I do not have?

Dr. Kershaw, will you please tell me how many individuals you treated for a Posttraumatic Stress Disorder prior to your first meeting with Ms. Amahl?

Dr. Kershaw, will you please tell me how many individuals you treated for a Posttraumatic Stress Disorder subsequent to your first meeting with Ms. Amahl?

Dr. Kershaw, will you please describe what your treatment plan for Ms. Amahl was at the time you began treatment?

Dr. Kershaw, will you please tell me if your treatment plan changed during the course of treating Ms. Amahl and if so, how did it change?

Dr. Kershaw, will you please tell me why you did not write out a formal treatment plan?

Dr. Kershaw, will you please tell me how many individuals you evaluated prior to your first meeting with Ms. Amahl who you found to have a Posttraumatic Stress Disorder?

Dr. Kershaw, will you please tell me how many individuals you evaluated subsequent to your first meeting with Ms. Amahl who you found to have a Posttraumatic Stress Disorder?

Dr. Kershaw, did you take a complete history of Ms. Amahl complaints or symptoms at the time that you first met her?

Dr. Kershaw, isn't it normal behavior for a Marriage and Family Therapist to take notes during their first meeting with someone who they may be treating?

Dr. Kershaw, did you make any notes during the first meeting you had with Ms. Amahl concerning her symptoms or complaints?

Dr. Kershaw, where are the notes that you made during your first meeting with Ms. Amahl?

Dr. Kershaw, I have your treatment or case notes that reflect 68 entrees made between September 21, 2010 and September 27, 2012. Will you please describe for me the exact process by which those notes were generated?

Dr. Kershaw, at the time you first met Ms. Amahl did you take a complete history of her current symptoms or complaints that included obtaining information about the qualitative nature of each of those complaints?

Dr. Kershaw, at the time you first met Ms. Amahl did you take a complete history of her current symptoms or complaints that included obtaining information about the frequency, intensity, duration, onset and course of each of those complaints?

Dr. Kershaw, will you explain to me why you did not take a complete history of Ms. Amahl's current symptoms or complaints at the time of your first meeting?

Dr. Kershaw, at the time you first met Ms. Amahl did you take a complete history from Ms. Amahl including obtaining information about her life and psychological status prior to January 13, 2010?

Dr. Kershaw, at the time you first met Ms. Amahl how much time did you spend with Ms. Amahl including obtaining information about her life and psychological status prior to January 13, 2010?

Dr. Kershaw, did Ms. Amahl have any psychopathology prior to January 13, 2010?

Dr. Kershaw, considering that you did not obtain a complete history from Ms. Amahl at the time of your first meeting, how can you be sure she did not have any psychopathology prior to January 13, 2010?

Dr. Kershaw, I am handing you a copy of page 468 taken from the DSM-IV-TR that describes the diagnostic criteria for a Posttraumatic Stress Disorder. Will you please tell me where in your report I can find a description of the specific complaints made by Ms. Amahl that indicates she met any of the diagnostic criteria other than perhaps Criterion A? (Note: Dr. Kershaw should be required to provide information about the qualitative nature of the specific complaints reported by Ms. Amahl as well as a description of their frequency, intensity, duration, onset and course.)

Dr. Kershaw, did you ever give Ms. Amahl a Mental Status Examination?

Dr. Kershaw, in discussing Ms. Amahl in your report you referred to her having some problems with both her memory and her concentration. As you probably know, a Mental Status Examination produces a set of observations that are made by the doctor under reasonably controlled conditions using a relatively standard set of examining techniques and questions that provides objective information about multiple mental processes, such as a patient's memory and concentration. Will you please tell me if you ever gave Ms. Amahl any tests of her memory or concentration that corroborate your statements about her problems in these areas?

Dr. Kershaw, will you please explain to me why you did not give Ms. Amahl a Mental Status Examination?

Dr. Kershaw, did you ever give Ms. Amahl any psychological tests?

Dr. Kershaw, considering that psychological testing is the only form of objective data that can be presented to the court, is open to public inspection and is capable of assessing an individual's credibility as well as any possible psychopathology, will you please explain to me why you did not give Ms. Amahl any psychological tests?

Dr. Kershaw, do you have any psychological testing data that indicate that Ms. Amahl was suffering from a Posttraumatic Stress Disorder or any other DSM-IV-TR psychological disorders at any time between January 12, 2010 and September 27, 2012?

Dr. Kershaw, prior to your report of October 30, 2012 did you have access to any reports from any mental health professionals who ever concurred with your diagnosis of a Posttraumatic Stress Disorder? (Note: If Dr. Kershaw refers to the April 19, 2011 report of Dr. Winston S. Moore, a neuropsychologist, it should be noted that on page 15 of his report Dr. Moore "diagnosed" a "post-traumatic stress syndrome and depression not otherwise specified," neither of which appear in the DSM-IV-TR. It also should be noted that an analysis of Dr. Moore's report reveals that there are insufficient data in that report to support the diagnosis of a Posttraumatic Stress Disorder or a Depressive Disorder Not Otherwise Specified (311), if that is what he had intended to diagnose. In fact, if one accepts Dr. Moore's MMPI-2 clinical scale data at face value, a dubious proposition considering that there are MMPI-2 validity scale data indicating that Ms. Amahl was not responding to the evaluation in an honest and frank manner, those clinical scale scores would indicate that she has significant chronic problems, which could easily antedate the motor vehicle accident. In approaching Dr. Moore's report it is relevant to take note of the nature of neuropsychological evaluations. These evaluations are generally intended to provide information about the individual's cognitive status with regard to assessing whether or not they have any organic or neurological impairment. The results of neuropsychological testing are typically used by neurologists who are attempting to assess neurological injuries that are relatively subtle and do not necessarily appear with the relatively gross imaging techniques typically used in radiological studies of the nervous system. As such, neuropsychological evaluations most often do not speak to the issue of whether or not an individual has had a psychiatric injury.)

Dr. Kershaw, considering your answers to the questions I have been asking you, at this point would you like to change any of the opinions expressed in your report of October 30, 2010 relating to your diagnoses, your conclusion that Ms. Amahl has suffered a psychiatric injury as a result of the motor vehicle accident of January 13, 2010, or your comments about her having had a psychiatric injury, a psychiatric disability or need for psychological and/or psychiatric care?

List of Appendices

Appendix A: A copy of page 468 of the DSM-IV-TR showing the diagnostic criteria for a Posttraumatic Stress Disorder.

Appendix A: A copy of page 468 of the DSM-IV-TR showing the diagnostic criteria for a Posttraumatic Stress Disorder.

Diagnostic criteria for
309.81 Posttraumatic Stress Disorder *(continued)*

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

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

Specify if:

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor