THE WETC PSYCHOLOGY NEWSLETTER

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"Find the Truth, Tell the Story"

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July, 2014
Volume 1, Issue 66

THE TEN COMMANDMENTS OF MENTAL STATUS EXAMINATIONS

"when one finds that the "rules" or "commandments" of a Mental Status Examination have not been followed, that is a good reason not to accept the doctor's conclusions about their diagnoses but also about the patient's disability, apportionment and the need for treatment."

The feedback I received on last month's newsletter about The Ten Commandments of Psychological Testing was so positive that I thought I would extend the discussion to Mental Status Examinations.

A Mental Status Examination is part of every psychological and psychiatric evaluation conducted in a medical-legal context. The other sources of information about a litigant's psychological condition are their life history and presenting complaints, the psychological testing, the medical records and any information that can be gleaned from their friends, relatives and work associates.

A Mental Status Examination is part of the doctor's face-to-face interview. It produces a set of observations of the patient that are made by the doctor using a relatively standard set of examining techniques and questions. The purpose of this month's newsletter is to point out what I consider the Ten Commandments of Mental Status Examinations. Violations of these commandments means that something is seriously wrong with the doctor's report and they may have provided conclusions that lack credibility and support, problems that can and should be pointed out during the taking of the doctor's testimony at a deposition or trial.

Essentially, during a Mental Status Examination the doctor observes, measures and comments on the behavior of the patient being evaluated. Specifically, the doctor is supposed to report on the patient's physical presentation; understanding of the examination; credibility; historical ability; relationship with the examiner; mood; cognitive processes such as memory, concentration, thinking and judgment; ability to perform basic tasks during the evaluation and social behaviors. All of the observations the doctor makes about the patient's physical presentation is information about the patient's signs. Signs are vastly different than symptoms, which are what the patient complains about or tells the doctor is wrong with them.

The Ten Commandments of Mental Status Examination

1. The Doctor Shall Not Provide Information About the Patient's Complaints in Their Report of the MSE

Considering that a Mental Status Examination produces information about the doctor's observation of the patient, it is inappropriate for the doctor to try to convey information about the patient's complaints or symptoms in their report of their Mental Status Examination. Thus, all statements that begin with the doctor stating, "Ms. X told me, stated, reported, complained, or indicated" are all ways of the doctor introducing the idea that they are about to tell you about the patient's symptoms or complaints, not their observations. There is a vast sea of difference between

the doctor telling you that they observed Ms. X being unable to explain herself and the statement that Ms. X complained that she was unable to get her ideas across in a conversation.

2. The Doctor Shall Not Provide Summary Conclusions About the Patient

At times you may come across a report in which the doctor states in his or her discussion of their Mental Status Examination something like, "Ms. X was obviously depressed." This is a summary conclusion. What may be missing are the doctor's observations that led to this conclusion. For example, patient's who are clinically depressed may present with deficits in attention and memory, sadness, tearfulness, crying or looking as if they are about to cry, irritability, indecisiveness and social withdrawal. The doctor must describe what they observed in these and other areas that led them to the conclusion that Ms. X was depressed. It is not enough simply to provide the bottom line. One always has to expect, if not demand, the data that led to the doctor's conclusions. If those observational data are not found, then the doctor's conclusions are unsupported and meaningless.

3. The Doctor Shall Discuss and Explain Any and All Inconsistencies Between the Patient's Complaints and the Doctor's Observations

Unfortunately, a very common occurrence in medical-legal reports is for the doctor to dutifully note that Ms. X complained about memory and concentration problems and then to provide information indicating that they did not observe any defects in the areas of memory and concentration. If the doctor does not describe those inconsistencies but waits until the reader discovers them for themselves they have demonstrated that their report is substantially flawed. It certainly is reasonable to expect an explanation of why Ms. X may have complained about memory and concentration problems but yet no such problems were observed during the face-to-face Mental Status Examination.

4. The Doctor Shall Provide Mental Status Examination Observations That Are Consistent With Their Diagnoses

If the doctor has diagnosed a Depressive Disorder it is very reasonable for the reader to expect the doctor's report to describe the observations they made that demonstrate that Ms. X was clinically depressed. The same is true for the diagnosis of an Anxiety Disorder. Additionally, if the doctor diagnosed any other disorder the doctor must provide the observations they made that support that diagnosis. For example, if the doctor diagnosed a Narcissistic Personality Disorder it is reasonable for the doctor to state what they observed during their face-to-face meeting with Ms. X that led them to that conclusion. If there are no such observations then the doctor's diagnosis is not credible and all the conclusions that flow from that diagnosis, such as those regarding the occurrence of a psychiatric injury, the need for treatment, psychiatric disability or apportionment are unwarranted.

5. The Doctor Shall Not Provide Information From a Mental Status Examination Checklist that is Completed by Either the Doctor or the Patient

On occasions reports are found in which it is apparent that the doctor did not actually administer a Mental Status Examination but asked the patient to check off items on a checklist that pertain to mental processes that would ordinarily be tested and observed by the doctor during their face-to-face interview. Additionally, at times the doctor will complete such a checklist themselves and simply make it the centerpiece or the sole contents of their report of their Mental Status Examination. Providing the data from a checklist is not the same as providing observational data nor does it present a complete picture of what the doctor actually

observed. It is simply another way for the doctor and/or the patient to provide summary statements about the patient's complaints. This is a "no-no" when it comes to reporting on the results of a Mental Status Examination.

6. The Doctor Shall Provide Observational Data About the Patient's Mood

A large proportion of the patients seen in medical-legal evaluations present with signs of depression and/or anxiety. Accordingly, when a physician has diagnosed a disorder characterized by depression and/or anxiety they must provide information about those observations. In this regard, patient's who are clinically depressed typically present with a variety of signs in their narrative such as statements of worthlessness, guilt, hopelessness, helplessness or low self-esteem. Behaviorally, depressed patients may exhibit sadness, crying, and/or social withdrawal. Similarly, patient's who are pathologically anxious may present with narrative statements of unrealistic fears or worries about threat, danger, unpredictability or uncertainty in their lives. Behaviorally, they may exhibit restlessness, fidgeting, hyperactivity, motor tension, vigilance, and/or apprehensive expectations. It is reasonable to expect the doctor to report on the narrative statements the patient made during their face-to-face interaction, as well as the specific behaviors observed by the doctor, which support their conclusions about the patient's mood.

7. The Doctor Shall Provide Measurements of the Patient's Memory

Many psychological disorders are accompanied by deficits in the patient's cognitive abilities. In fact, memory is one of the cognitive processes frequently affected by mental disorders. Fortunately, objective observational data are easily obtained during a Mental Status Examination and should be reported by the doctor. There are many techniques for measuring memory during a face-to-face interview. For example, one method is to present the patient with a sequence of numbers, say, 7-3-6-1-9-2, at the rate of approximately one a second and vary the length of the sequence to determine what they are capable of recalling. Another simple technique is to point out three or four objects in the examination room and ask the patient to recall them after a few minutes. Obviously, it is not sufficient for the doctor to simply summarily state that Ms. X's memory was deficient.

8. The Doctor Shall Provide Measurements of the Patient's Attention and Concentration

Another mental process that is often adversely affected by psychopathology is the patient's ability to concentrate or attend. Once again, objective observational data about this ability is easily obtained during a face-to-face interview. Specifically, depending on the patient's educational background, the doctor can measure their ability to concentrate by asking them to count backwards from 100 by 7's or 3's. The patient's level of performance reflects their ability to concentrate. Once again, it is not permissible for the doctor to simply provide a summary conclusion that Ms. X's concentration was impaired.

9. The Doctor Shall Provide Measurements of Complex or Higher Order Cognitive Processes

Just as memory and concentration are affected by psychopathology, higher order cognitive processes are similarly adversely affected. Accordingly, during a Mental Status Examination of a person with psychopathology the doctor may observe deficits in one or more higher order cognitive processes such as judgment and insight. In particular, these processes can be measured with a variety of objective techniques that yield easily reported observational data. For example, insight can be measured by asking the patient to interpret proverbs such as "The squeaky wheel gets the grease." Similarly, judgment can be measured by simply asking the person what they would do if they found an unmailed stamped addressed envelope on the street. Once again, it is not sufficient for the doctor to provide summary conclusions, as they must support any such statements with observational data.

10. The Doctor Shall Provide Observational Data of the Patient's Social Behavior

A psychological evaluation is a social interaction. When the patient arrives in the office they are typically greeted by staff who interact with the patient. Generally, it is the staff that explains the examination process, has the patient sign consent forms, and proctors any psychological testing not administered by the doctor. Thereafter, the social process continues with the patient meeting and interacting with the doctor. What did the doctor observe with respect to the patient's ability to socially interact with the doctor and the staff? Did the patient behave in a socially appropriate and normal manner or were there any abrasive, compulsive, bizarre, aggressive, depressed, anxious, distancing, overly emotional or morbid behaviors. Observations of these factors and others shed light on the patient's social skills and their psychopathology and should be discussed in the doctor's report of their Mental Status Examination.

In summary, there are many different ways to conduct and report on the results of a Mental Status Examination that can destroy the credibility of any medical-legal psychological or psychiatric report when not reported appropriately by the doctor. In reading and evaluating psychological or psychiatric reports it is obviously quite important to know what the doctor should have done and reported so that it can be compared with what was done and described. In addition, when one finds that the "rules" or "commandments" of a Mental Status Examination have not been followed, that is a good reason not to accept the doctor's conclusions about their diagnoses as well as about the patient's disability, apportionment and the need for treatment.

This is the sixty-sixth 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.