# THE WETC PSYCHOLOGY NEWSLETTER

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**"Find the Truth, Tell the Story"**

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# Cross Examining Shrinks: Leckart's Third Rule

In September, 2014 my monthly newsletter was devoted to cross-examining psychologists and psychiatrists and stated Leckart's First Rule, Never ask the doctor about the patient, confine your questions to the doctor's report. As I pointed out, by doing so, no new information can be introduced at the deposition that is not in the doctor's report. In October, 2014 my monthly newsletter was devoted to Leckart's Second Rule, which states that the focus of a deposition should always be on the doctor's diagnosis.

Now, on to Leckart's Third Rule.

Leckart's Third Rule states that the attorney should always determine if the doctor's history supports their diagnosis.

The crucial question is, "Has the doctor's report demonstrated that they have obtained sufficient data from the patient's life history and presenting complaints to support the conclusion that the patient has a DSM-IV-TR diagnosis?"

Do not let the doctor stop at the statement, "he's depressed." He or she must state in their report what the patient means when they complain about depression. The heart of the diagnosis is the patient's symptoms or complaints. Always demand the data!



***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.***

This brings us to the point where we should note that a complete history of the patient's symptoms should provide information about the qualitative nature of those symptoms as well as data about their frequency, intensity, duration, onset and course over time. Putting all the first letters of those factors together we come up with the heuristic device of Q-FIDO-C.

First, the doctor must provide information of the qualitative (Q) nature of the patient's complaints. Let's take depression as an example since most people who have had psychiatric injuries complain about being depressed. What should appear in the doctor's history?

When a doctor reports that a patient complained about being clinically depressed that is only the beginning, not an end to their history. The doctor should be saying something like this during their history taking:

"Ms. Smith, I've been in practice for many years and have seen numerous patients who are depressed and I know from experience that when someone complains about being depressed that is only the beginning of the story. So I have to ask you, when you get depressed, What do you feel, think and do that will tell me more about the nature of your depression"?

When asked this question in this way patients who are clinically depressed talk about feelings and thoughts 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. These patients also often report symptoms of fatigue, frustration, weight changes when not dieting or attempting to gain weight, bodily aches, decreased energy, frustration over minor matters, insomnia, anger and/or decreased libido. A complete history needed to support the doctor's diagnosis delves into a thorough description of these complaints as compared to the doctor simply summarily stating, "Ms. Smith complained about being depressed."

Just describing the qualitative nature of a patient's complaints is not enough. The doctor must described the frequency (F) of those complains. This is especially important since many of the disorders found in the DSM-IV-TR require that the patient have their complaints with some frequency. For example, in the case of a Major Depressive Disorder the complaint of depression must be found to occur at least "nearly every day." Clearly, if the doctor has taken and reported on a complete history there should be one or more statements indicating how frequently the symptoms are present.

The intensity (I) of a patient's complaints presents an interesting problem for the doctor's history taking. Since psychological complaints cannot be seen, how do you measure how intense the are? The most fruitful way is to ask the patient to subjectively describe the intensity of their complaint by asking them to rate that complaint on a 10-point problem severity scale with a "1" being the least severe complaint that could be called a problem and a "10" being the most intense problem they can imagine. Unfortunately, two patients who rate the same complaint with the same number may have complaints that have very different intensities. This is what is called low intra-rater reliability. However, the numbers assigned to the patient's complaints are quite useful to understanding the patient when the patient tells you that their feelings of low-self-esteem are a "10" and their feelings of difficulty thinking rate a "2." Now you know that the complaint of low self-esteem is quite important although numerically one never knows how much more important a "10" is than a "2."

Onset (O) is essentially a no-brainer. The doctor simply asks the patient when their specific symptoms began. Similarly, the duration (D) of a patient's complaints is determined by another simple question the doctor must ask. "Ms. Smith, when you get depressed, how long does that depression usually last?

The last dimension that must be assessed in taking and reporting a history of the patient's complaints is the course (C) of those complaints over time. In this respect, there are multiple possibilities. To name just a few, (a) the complaint has been gradually increasing over time with no relief, (b) the complaint has been gradually decreasing over time, (c) the complaint first increased, then it decreased and then it leveled off. You get the idea! The important thing is that the doctor must address this issue in providing a complete history. The specific course of the complaint may not be as important as the presence of the data indicating what has occurred in the past. One thing that is clear is that without those data the doctor's history is incomplete.

Finally, in taking a deposition from a doctor who has not diagnosed a disorder for a patient who you believe has some psychopathology all of the questions that must be asked are aimed at determining if the doctor has taken a complete history. Here one cannot be satisfied with a simple statement from the doctor like, "The patient had no psychological complaints or symptoms"? Under these circumstances the attorney must ask, "Where in your report can I read about the manner in which you took the patient's history? " A credible report will contain statements about the doctor's methodology such as, "In determining that Ms. Smith did not have any symptoms or complaints I was very careful in asking her to describe all of the physical and psychological symptoms or complaints she had in the last approximately 30 days." If the doctor reports that she had no complaints when asked about them in that manner, the doctor's report should also state that as a follow-up they asked, "Ms. Smith, at any time since your injury have you had

any other complaints or symptoms that have gone away"? Further, if the doctor's report is to have a high level of credibility they will also note that they went on to ask something like, "Ms. Smith are you depressed? " They also should ask and report on the responses to the same question about a variety of other symptoms such as sleeping, fear, decision-making, memory, concentration, etc. While it is always difficult to prove the negative, if those data are not in the report then it is reasonable to conclude that there is no evidence in that document indicating the physician has taken a complete history.

In short, in taking a psychologist's or a psychiatrist's deposition or trial testimony, it is important to determine if the doctor has provided a complete history of the patient's complaints that supports the DSM-IV-TR diagnostic criteria. If the history is deficient in providing information about the symptoms in terms of their qualitative nature as well as their frequency, intensity, duration, onset or course over time there is no support for the doctor's diagnosis. Most importantly, if you are deposing a doctor who has not diagnosed a disorder, and you believe there is one that has been missed, during the deposition simply ask the doctor, "Where in your report can I read about the methodology you used in your attempt to obtain a complete history of Ms. Smith's complaints?" If adequate information is not present in the doctor's report then there is no supporting data for the absence of a diagnosis.

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This is the seventieth 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.