

BRIDGING THE GAP

A biopsychosocial newsletter for healthcare professionals

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PEARSON

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Taking an evidence-based approach to forensic assessment of psychological issues in chronic pain patients

While William Deardorff, PhD, ABPP, has performed many roles as a clinical health psychologist over the years, he has discovered a certain passion for forensic evaluations. Having expanded his practice into this area 20 years ago, he now spends about 75 percent of his time conducting evaluations of psychological issues in physical injury cases. “Tracking down all the relevant information often presents a challenge—but I really enjoy the process of getting to the truth of the situation,” Deardorff says.

Practicing in the state of California, Deardorff conducts five to 10 medical-legal evaluations a month, receiving referrals from AME physicians, insurance companies, and attorney groups that are handling workers’ compensation cases. From start to finish, he takes an evidence-based approach in investigating the issues. “The old-world style of prefacing your recommendations with ‘In my medical opinion...’ doesn’t cut it anymore with the courts,” he says. “Your conclusions need to be highly defensible, backed by solid research.”

Thoroughly researching patient records and pertinent health topics

“My first step is to do an in-depth review of patient records,” Deardorff says. “I’ll look at medical history including records prior to the alleged injury, employment records, surveillance tapes—any and all available data.”

“I consider it very important to do this review myself, rather than hiring a record review service to give me a summary,” he says. “I discover all kinds of details that may either support or be inconsistent with what I find through the clinical interview and the psychological tests I give the patient. For example, a patient might claim that his back problems were caused solely by a recent injury yet his medical records may show a long history of back problems; that raises a red flag for me.”

In addition, if the case involves a physical problem or pain issue with which Deardorff is not familiar, he will spend time learning about the topic by reviewing journal articles and reliable sources on the web. “This research is a valuable element of the evidence-based approach I take,” he says.

Eliciting patient cooperation

Next, Deardorff conducts a clinical interview with the patient. “I focus on putting patients at ease,” he says. “They often are defensive when they arrive. They know the stakes are high and, on a conscious or unconscious level, they are trying to prove an injury and damages. Using an ‘interrogation’ approach isn’t helpful. If patients remain highly defensive, this will affect what they reveal to me in the interview and how they approach the psychological testing. So I want to build trust with them. I’ll start with small talk, invite them to make themselves comfortable, ask them how their drive was, et cetera. Then I’ll ask them to tell me in their own words what happened relative to the injury.”

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“This test [BHI™ 2] provides a number of scales that are especially helpful in evaluating work injuries and are not found in other tests.”

“I encourage patients to let me know if they have questions or concerns. If they say, ‘Well, you’re working for the insurance company, so you’re not on my side,’ I’ll tell them, ‘I’m here to find out the truth and I need your help to do that. If you have a legitimate injury, then that’s what my report will say.’ I find that nine times out of 10, patients become cooperative when I take a conversational approach.”

Along with the information that patients share during the interview, Deardorff takes into account his behavioral observations as another source of data. “A pain patient might come in limping or using a cane but after 5 minutes, the pain behaviors disappear,” he says. “Or, during the interview, I’ll ask a patient to rate his pain and he’ll say that it’s 10 out of 10. Yet I observe that he has been sitting for 2 hours, not grimacing, not requesting to stand up, and not shifting positions. Or, the patient will tell me that her concentration and memory are terrible, yet I see that she has completed 4 hours of testing on schedule without difficulty and that the test results are valid. Behavioral observations play a valuable role in my analysis.”

Standardized psychological tests provide strong support

Deardorff uses several standardized psychological tests in his evaluations, including the MMPI®-2, the BHI™ 2 (Battery for Health Improvement 2), the MCMI-III™ (Millon™ Clinical Multiaxial Inventory-III), the BAI® (Beck Anxiety Inventory®), and the BDI®-II (Beck Depression Inventory®-II) instruments. “All of these tests have been developed through rigorous research and have been extensively used in published studies, which is critical for forensic cases,” he says. “Plus, they are easy to administer and I can score them quickly on my computer using Q Local™ software. Computer scoring also ensures that the test will be scored properly, including all relevant scales. In reviewing many psychological test batteries, I often see hand-scored MMPI-2 profiles in which many important scales have been omitted. That creates a serious problem because the attorneys will hit you hard on those issues.”

Deardorff also uses several public-domain tools, such as pain ratings, pain drawings, activity scales, and sleep disruption scales. “These tools, which are often face valid, can help shed light on specific pain-related symptoms when used in conjunction with comprehensive tests that include validity scales,” he says.

Testing is conducted on the same day as the clinical interview and usually takes about 4 hours although Deardorff will break the testing into two sessions for patients with severe pain.

MMPI-2 test helps determine credibility

Deardorff always has used the MMPI-2 test as the bedrock of his forensic evaluations. “Since my initial goal is to determine whether the patient is credible, I look at the MMPI-2 first because it has excellent validity and credibility scales,” he says.

He emphasizes that traditional MMPI-2 interpretive statements may not apply when using the test with a chronic pain patient and that ethical principles of psychological testing mandate that the psychologist be aware of these distinctions.

“In particular, my interpretation of the 1 Hs (Hypochondriasis), 2 D (Depression), and 3 Hy (Hysteria) scales may be very different than a traditional interpretation since these scales are indicators of illness behavior,” he says. “If these scales are elevated, the pain patient is expressing a lot of suffering. We define suffering as pain perception plus emotional reaction to the pain—and it’s our job as psychologists to measure the degree of suffering. The patient may be expressing far greater or far less suffering than what would be expected based on objective findings or input to the nervous system due to the physical injury.”

He also takes a close look at Scales 6 Pa (Paranoia), 7 Pt (Psychasthenia), and 8 Sc (Schizophrenia) because they assess how likely the patient will be able to cope with being well. “As these scales go up, one can surmise that the person may have increasing problems with coping and may seek the haven of chronic pain or the sick role,” he says.

In addition, he points out that patients with chronic pain tend to have artificially elevated scores on scales loaded with physical symptom items, such as Scale 8 Sc. “A pain patient

may not be showing any psychotic symptoms yet she may report odd sensory experiences or other physical symptoms that are not supported by the physical exam findings—one needs to be aware that pain patients often describe their suffering in this way,” he says. “For this reason, analysis of the MMPI-2 subscales is critical for an accurate interpretation.”

To address concomitant emotional or psychological factors, Deardorff often will provide two interpretations in his report: one interpretation relative to chronic pain and another interpretation relative to enduring personality features not related to the pain, such as long-standing low-grade depression, anxiety, or a tendency to be more dependent.

The MMPI-2 test also helps Deardorff ascertain reasons for the patient’s response to previous treatment. “I often see patients who have had multiple surgeries, medication regimens, or other treatments and they’ll tell me that none of it has helped them,” he says. “The MMPI-2 reports on psychological factors that help explain why the patient didn’t respond well—and it helps predict whether the patient is likely to respond well to *any* type of intervention.”

BHI 2 scales prove useful in assessing work injuries

The BHI 2 provides Deardorff with another reliable measure of validity and credibility—and he likes the fact that it is normed on chronic pain and physical rehabilitation patients as well as a community sample. “This test provides a number of scales that are especially helpful in evaluating work injuries and are not found in other tests,” he says. “These include the Physical Symptoms, Substance Abuse, and Perseverance scales, plus psychosocial scales such as Job Dissatisfaction, Doctor Dissatisfaction, and Family Dysfunction. The BHI 2 also provides content areas within each scale that help distinguish the specific reasons for problems, which I find very useful.”

MCMI-III results help identify pre-existing personality issues

The test battery also may include the MCMI-III test, which helps assess *DSM-IV*[®]-related personality disorders and clinical symptoms. “I look at MCMI-III results in conjunction with MMPI-2 results to help evaluate the contribution of long-standing personality issues to the current injury,” he says. “In California, the court expects us to apportion causation: How much of the patient’s current impairment is caused by the alleged injury and how much is caused by a pre-existing condition? If the testing provides evidence of a pre-existing personality disorder that contributes to the impairment after the injury, I’ll apportion a percentage to this causation.”

In addition, Deardorff uses the MCMI-III test to help determine why a patient has not responded well to previous treatments—and to help predict how the patient will respond to future treatments. “For example, if a patient’s score is highly elevated on the Dependent, Histrionic, or Borderline scales, they are not likely to do well in a pain program,” he says. “The information provided by the MCMI-III not only helps inform the court’s decision on the case, it also helps the patient’s care team determine appropriate treatment planning.”

BAI and BDI-II offer the benefit of brevity for pain patients

Deardorff also may administer the BAI or BDI-II tests, which he notes are frequently used for forensics. “I like these instruments because they are well-researched—and they are very brief, which is a benefit for chronic pain patients,” he says. “However, I look closely at individual items on these tests, such as those related to sleep disruption or weight gain. People with chronic pain often experience these symptoms, so if scores are elevated based on the patient’s response to these items, I might increase the cutoff for self-rated depression or anxiety. Of course, in a forensic arena, credibility of the patient must be established for the results of these face-valid tests to be useful.”

Three guidelines for writing effective reports

Once Deardorff has completed the records review, research, interview, and testing, he synthesizes all the data to develop his recommendations. “I always write my reports assuming I am going to be deposed,” he says. “While I rarely am required to appear in court, I am often deposed—and even if I’m not going to be deposed for the case, it’s helpful to have that mind-set as I am drafting the report.”

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“It’s imperative to back up your conclusions with data from standardized, well-researched tests that meet the Daubert standard, such as the Pearson assessments I administer.”

He offers several guidelines on how to write an effective report. First, present evidence-based conclusions. “To simply say, ‘It is my expert opinion that this person is completely disabled in all aspects of his life because of his injury and pain’ isn’t going to fly in court,” he says. “It’s imperative to back up your conclusions with data from standardized, well-researched tests that meet the Daubert standard, such as the Pearson assessments I administer.”

Second, use clear, concise language. “Psychologists are notorious for being verbose, piling on the adjectives,” Deardorff says. He gives some examples from actual reports: “hysterical tendencies,” “functional or imaginary pain,” “channeling rage into increased physical complaints.” “The courts don’t understand this jargon and it is not appropriate,” he says.

Third, keep in mind the purpose of the evaluation. “If it’s a pre-surgical evaluation for spinal surgery, the court does not want you to go off track talking about personality disorder and psychological injury,” he says. “On the other hand, if the patient has had an orthopedic assessment to address impairment and you have been asked only to address psychological injury related to the pain, then stick specifically to that issue.”

CE website offers evidence-based courses

Because Deardorff saw a gap in continuing education for clinical health psychologists, he recently launched BehavioralHealthCE.com, which is approved by the APA and other organizations to offer CE credits. The site offers evidence-based courses in behavioral health written by experts in their fields, including courses on the use of psychological tests in forensic settings. There is no charge for viewing the courses or for taking the tests; CE credits can be purchased directly through the site. “Our goal was to create a very easy-to-use site so that psychologists, as well as the general public, will have ready access to accurate health information,” he says.

In-depth research serves all parties involved

“I look at every forensics case as a quasi-research project,” says Deardorff. “The nice thing is that you get reimbursed by the referral source for everything you do—records review, research, patient interview, testing, analysis, and report-writing. This allows me the time to dig deep in gathering pertinent information. I might spend 20 or more hours from start to finish on a case. By the time I write my report, I feel confident that I have developed very concrete, objective, and defensible support for my conclusions. Being able to investigate cases so thoroughly serves the system well—and it brings me a lot of personal satisfaction.”

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William W. Deardorff, PhD, ABPP, is board-certified in clinical health psychology and specializes in pain and spinal disorders. He is the founding president of the American Academy of Clinical Health Psychology and a fellow of the American Psychological Association in two divisions: Health and Independent Practice. He is an examiner for the American Board of Professional Psychology and, as an assistant clinical professor at the UCLA School of Medicine, he is active in research and teaching. Dr. Deardorff has lectured extensively and published numerous books, book chapters, and scientific articles on clinical health psychology, with a special emphasis in pain management, preparing for surgery, and pre-surgical psychological screening.

See Dr. Deardorff’s website, BehavioralHealthCE.com, for evidence-based courses on behavioral health.



Clinical Assessment
19500 Bulverde Road
San Antonio, TX 78259
PsychCorp.com
800.627.7271, ext. 263200

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