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# CHAPTER 716

# Deposing Mental Health Experts on Post-Traumatic Stress Disorder (PTSD)*

SYNOPSIS



## § 716.01 Post-traumatic Stress Disorder (PTSD) In Litigation

Post-Traumatic Stress Disorder (PTSD) is a prevalent reaction to physical and emotional injuries and accidents. PTSD is the only diagnosis in which causation is implied by the diagnosis itself–by definition it occurs in reaction to a stressful life event—and thus does not have to be independently proven along with damages. Because this diagnosis has been used to successfully litigate and has resulted in substantial financial judgments for psychological damages, it has become a popular cause of action.

The diagnostic criteria for PTSD are almost entirely subjective. Since the criteria are published, readily available and easily learned,


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the symptoms of PTSD are easy to claim, to exaggerate and to fake. Therefore independent psychiatric and psychological examination is essential to determine if the diagnostic criteria for PTSD have been met, to perform a differential diagnosis to rule out other conditions that have overlapping symptoms with PTSD, and to rule out malingering or symptom exaggeration.

The attorney who is thoroughly familiar with all the diagnostic criteria and issues of causation related to this disorder will be much more effective in deposing experts than an attorney who uses the deposition to learn about the criteria from the expert. In this chapter we describe the diagnostic criteria for PTSD and we describe other mental disorders that have overlapping symptoms with PTSD. We discuss issues related to causation, and describe the role of pre-existing personality disorders in PTSD litigation.

We will also provide transcripts from depositions of a psychologist and psychiatrist on the same case of alleged PTSD (identifying information is disguised). We will offer our comments about the attorney's questions and lines of investigation and conclude with some summary points to be learned from this deposition.

## § 716.02 Deposing the Expert Witness About PTSD Claims

The broad purpose of deposing a mental health expert is to establish what conclusions the expert reached, how those conclusions were arrived at, where the expert's strengths lie and where there are weaknesses in the expert's methods, data sources and inferences. An attorney who is well prepared to depose a psychiatrist or psychologist on PTSD should come away from information that will aid him in settlement conferences and that will be critical for cross-examination if the case goes to trial. In contrast, a poorly prepared attorney will come away from the encounter more informed about PTSD but with relatively little information he can use effectively to advocate for his client.

To effectively depose a mental health expert it is essential for the attorney to understand what constitutes a thorough and objective evaluation of PTSD. One of the most frequent mistakes plaintiff's attorneys make, is to ask treating psychotherapists to "wear two hats," one as therapist, one as independent forensic expert. The two roles are inherently in conflict and incompatible. Assuming both roles also raises certain ethical issues.

The role of a treating therapist is to empathize with his patient, to try and understand the patient's *subjective* reality, from the

patient's point of view, and to help the patient. As a psychotherapist, the patient's needs and interests are primary It is *not* the therapist's primary role to question the patient's credibility, to thoroughly investigate all available data concerning the patient's allegations, to raise the possibility of malingering or secondary gain, or to provide opinions that might be contrary to his patient's interests. These are forensic concerns.

To an independent medical or psychological evaluator, the plaintiff's interests (and the defendant's) are secondary–the primary obligation is to conduct an independent examination to provide conclusions based on sound scientific evidence to the court. This often means coming to a conclusion that may harm what the patient and/or his therapist considers his best interests. Finally, it is the ethical obligation of the independent expert to arrive at truly independent medical or psycho-legal conclusions. Thus, the expert must be willing and able to evaluate such critical dimensions as credibility and the possibility of malingering as well as issues of "secondary gain."

Furthermore, it is important to note that an independent psychiatric or psychological expert specifically does not have a doctor-patient relationship with the plaintiff and the plaintiff must be informed of the absence of statutory confidentiality privileges prior to the expert conducting an interview or proceeding with psychological testing. The plaintiff must give permission for the proceeding to go forward on the basis of having waived his rights to confidentiality.

Another common mistake that both defense attorneys and plaintiff's attorneys make is to hire an expert to only perform a record review without interviewing or testing the patient. In some circumstances a record review alone may be sufficient but it is always insufficient in complex cases where the other side has an independent examination performed.

A through and complete independent examination should address the following questions:

1. Do the plaintiff's symptoms meet the diagnostic criteria in the Diagnostic and Statistical Manual of the American Psychiatric Association, 4th edition (Text Revision (DSM-IV TR) for PTSD? Most importantly, are the two standards of the event criterion met, both of which are required in order to fulfill diagnostic Criteria A, as specified in the DSM-IV:
   a. "The person experienced, witnessed, or was confronted with an event or events that involved actual or

threatened death or serious injury, or a threat to the physical integrity of self or others," or

b. "The person's response involved intense fear, helplessness or horror. In children, this may be expressed instead by disorganized or agitated behavior."

This threshold is the only objective criteria, and if it isn't met, the patient does not qualify for a PTSD diagnosis no matter how emotionally stressed he may be.

2. Does this individual have any mental disorders? Do any of the disorders pre-exist and or co-exist with the occurrence of the alleged injurious event (i.e. were they contributing *proximate causes)?*
3. What level of credibility can be accorded to the individual's self-report? Is there any evidence that the plaintiff might be malingering or exaggerating subjective discomfort or dysfunction. Is the plaintiff straightforward, direct and honest or does the plaintiff appear guarded, defensive and manipulative? Is there any evidence the plaintiff is basing his claim on secondary gain? (The *secondary gain from illness is an indirect benefit obtained through an illness including monetary and disability compensation, avoidance from stressful situations and responsibilities and increased attention; the primary gain is relief from emotional conflicts and anxiety through the use of a defense mechanism or other psychological process).*
4. Is there any evidence that the plaintiff might have had pre-existing personality disorders or other psychiatric conditions that pre-dated the alleged injury and might account for his post-injury—reaction and symptoms?
5. Are there any motivations, other than what the plaintiff claims, that might explain why a lawsuit was filed at that particular time against that particular defendant?
6. If the plaintiff sustained a valid physical and or mental injury, what effort did they make to obtain proper treatment or did they fail to mitigate the injury?

## § 716.03 Key Points for the Deposing Attorney to Consider

The attorney should be familiar with the time course and natural history of stress disorders and the range of possible symptoms traumatized individuals exhibit. The distinctions between Acute

Stress Disorder, Posttraumatic Stress Disorder, and other non-stress related anxiety disorders are especially important. In addition, some of the symptoms of normal grief reactions and mood disorders as well as some personality disorders overlap with PTSD.

Familiarity with depositions in general may not be sufficient for deposing psychiatric and psychological experts. The attorney should either be thoroughly familiar and experienced within this area of discovery or he should retain an expert consultant to advise him. A minimum preparation would be to read the sections of the DSM-IV that describe anxiety disorders in general and PTSD in particular. The attorney needs to be familiar with the distinction between an Acute Stress Disorder (which has a limited time course for a month or less) and PTSD, in which symptoms occur for more than a month. The attorney must be familiar with the distinction between acute symptomatic disorders (like PTSD, depression, anxiety listed on Axis I) and personality disorders (listed on Axis II) of the DSM-IV. Personality disorders such as paranoid or narcissistic personality disorder may pre-exist or co-exist with the acute Axis I symptoms and may explain part or all of the symptomatic presentation of the plaintiff.

Attorneys should be familiar with the CV of the expert and any report he has written in the case and should seek to retain experts, separate from the therapist treating the patient, to advise, consult and whenever possible perform an independent mental examination ("IME") of the plaintiff. Especially when there is a report submitted by the expert (or clinical records created by the treating therapist), the deposing attorney should have a conference with his own expert and solicit clarification of ambiguous terms or concepts as well as suggestions for areas to be explored in the deposition.

The defense counsel will make vigorous efforts to obtain primary data sources concerning the plaintiff. Actual psychiatric clinical notes and raw data from psychological testing by licensed clinical psychologists will be subpoenaed by the defense. Plaintiff's experts should review all of these documents as well in order to advise plaintiff's counsel and prepare deposition and trial strategy concerning any contradictions or inconsistencies between these records and elements of the plaintiff's complaint.

An attorney has to judge the adequacy of an expert's qualifications, methods and conclusions. The attorney deposing a psychiatrist or psychologist needs to be familiar with the training, education and methods used by forensic psychiatrists and psychologists in order to establish the expert's credibility in arriving at his conclusions. Since so many of the symptoms are based on the plaintiff's

subjective self-report, how did the expert determine the validity and credibility of the plaintiff's account, or did the expert (or treating therapist) take the patient's claims at face value? Did the expert evaluate the possibility of malingering or secondary gain? Did the expert employ interview methods or psychological tests that reach beyond the plaintiff's self-report? Did the expert review other sources of information besides the patient's report, for example, collateral interviews, medical, legal, academic and employment records? Did the expert rule out other acute mental disorders (anxiety disorders, mood disorders, somatoform disorders) and personality disorders that might have symptoms that overlap those of PTSD or might explain the motivation of the plaintiff in bringing the lawsuit?

## § 716.04 Deposition by Plaintiff's Counsel of a Forensic Psychologist

The following is a verbatim sample from a deposition of a forensic psychologist, Saul Rosenberg, Ph.D. retained by the defense. Plaintiff Counsel (Mr. Griffith) represented Mr. Carson in a claim of PTSD arising from an alleged false arrest. Defense Counsel is Mr. Warren. Identifying names, places and dates have been changed and disguised to protect the privacy of the individuals (except Dr. Rosenberg the deponent and co-author of this chapter).

EXAMINATION BY MR. GRIFFITH

**Q.** You're Dr. Saul Rosenberg; right?

**A.** WITNESS: Yes.

**Q.** Did you receive a notice of taking deposition?

**A.** Yes, I did.

**Q.** You were — it's my understanding you were retained by Mr. Warren or his firm to act as an expert witness to be available to give testimony at the trial of this case. Is that your understanding, too?

**A.** Yes.

**Q.** Have you ever worked for Mr. Warren or his firm before?

**A.** No, I have not.

**Q.** Have you ever given deposition testimony before?

**A.** Yes, I have.

**Q.** About how many times?

**A.** 30.

**Q.** Have you ever testified in court before?

**A.** Yes.

**Q.** About how many times?

**A.** Seven to ten.

**Q.** Did you bring a curriculum vitae with you?

**A.** Yes, I did.

**Q.** When were you first contacted in connection with this case?

**A.** Between three to six weeks ago.

**Q.** Who contacted you?

**A.** Mr. Warren.

**Q.** Okay, good. What did he say to you, and what did you say to him?

**A.** He said that Dr. Levy had recommended that I do psychological tests on Mr. Carson.

**Q.** Have you ever worked with Dr. Levy before?

**A.** Yes, I have.

**Q.** Have you ever worked with him before on matters that related to court cases?

**A.** Yes.

**Q.** About how many times?

**A.** Five.

**Q.** Do you remember the names of any of those cases?

**A.** Yeah. Cases that went to trial? Or I think actually all of these settled, so it may be court records, but is that okay?

**Q.** Yeah, that's okay.

**A.** Roger Knight versus the Paul Revere Insurance Company

**Q.** What court was that in?

**A.** This circuit. San Francisco.

**Q.** What kind of case was that?

**A.** It was a case where the plaintiff was requesting insurance benefits that the Insurance Company denied.

**Q.** And who did you — were you retained as an expert?

**A.** I was retained as an expert by the defense counsel for the insurance company.

**Q.** Do you remember who that was?

**A.** Yes, David Van De Camp.

**Q.** And do you remember who the opposing counsel was?

**A.** I don't. I never actually had any contact with opposing counsel. It has not progressed.

**Q.** What's another one?

**A.** It's one that's currently ongoing right now, I'm not sure who. This is a plaintiff case where plaintiff's attorney retained Dr. Levy and myself to evaluate.

**Q.** And do you know what kind at lawsuit, personal injury or bad faith?

**A.** Let me think how I'd characterize that. It was a car accident in which the plaintiff was injured, and so it was a personal injury.

**Q.** Is that San Francisco also?

**A.** Yes.

**Q.** Can you think of another one?

**A.** I'll start with the part I remember. The attorney is Robert Reznikoff. It's a case of — it's a medical case involving a physician and his ability to practice.

**A.** [Mr. Griffith inquires about a number of prior lawsuits in which the deponent was an expert witness.]

**Q.** About how long have you been working with Dr. Levy in these court cases? What I'm asking is what period of time are we talking about here?

**A.** It is a couple years, two years.

**Q.** When you were retained by Mr. Warren or his firm, what were you asked to do?

**A.** Mr. Warren said that Dr. Levy had requested I do psychological testing, and that's what he was calling me to do, to administer psychological tests.

**Q.** Did he tell you what the lawsuit was about?

**A.** Yes.

**Q.** What did he tell you in general terms?

**A.** That Mr. Carson was involved in a lawsuit in which the circumstances of the lawsuit were that he was at a community meeting, that he brought some garbage bags with him and dumped them on the floor to demonstrate the

problem he claimed was caused by residents in a city owned facility next to his property; he claimed the residents were leaving garbage, alcohol bottles, drug paraphernalia etc. on his property. He was arrested for disturbing a public meeting, and he is claiming that he was injured in that process. I was being retained as a psychologist to evaluate what mental conditions, if any, he is currently suffering from.

**Q.** Did the facts of the arrest and the things that took place, that flowed from the arrest, did those facts play any part in any conclusions you reached about Mr. Carson?

**A.** MR. WARREN: Objection, assumes facts not in evidence, vague and ambiguous. You can answer.

THE WITNESS: Could you say the question again, please.

**Q.** I'm trying to know something about the facts of the case, and what I'm trying to get at is whether what you did is virtually independent of that, or do you factor that into your evaluation when you've come to any conclusion you have come to. And I haven't asked you yet what your conclusions are, but I'm going to eventually. So what I'm saying, were you influenced by the facts in any way?

**A.** MR. WARREN: Objection. It's vague and ambiguous, assumes facts not in evidence, and lacks foundation.

THE WITNESS: Could you ask the question again.

**Q.** Let me ask you what your conclusions were.

**A.** Okay.

**Q.** Maybe that's not a bad place to start.

**A.** My first conclusion is that Mr. Carson is suffering from a Paranoid Personality Disorder, meeting the criteria from DSM-IV. Do you want me to list my conclusions?

**Q.** Yes.

**A.** Just keep going. Number two, Mr. Carson is suffering from a number of personality characteristics that affect his behavior. What I mean is what are described as narcissistic and obsessional personality characteristics. To now complete this thought, what the formal diagnosis would be is Paranoid Personality Disorder with narcissistic and obsessional features. Mr. Carson is also suffering from two Axis I DSM-IV diagnoses, Anxiety Disorder Not Otherwise Specified, usually abbreviated as N.O.S., and Depressive Disorder, also N.O.S., not otherwise specified.

**Q.** Did you come to any other conclusions?

**A.** Yes.

**Q.** What?

**A.** Mr. Carson has superior verbal intellectual ability.

**Q.** Anything else?

**A.** There are psychological criteria or psychological states or characteristics that are used to make these diagnoses, so there is a long list of those that constitute the evidence for the diagnosis. Would you like to hear that list now?

**Q.** I'll get to that. I just want to make sure I have an idea of what your final conclusions are. Paranoid personality and the depression?

**A.** I can give you an overview of the major conclusions, then we can —

**Q.** That's a good way to do it.

**A.** I specifically concluded that Mr. Carson is not suffering from Post Traumatic Stress Disorder. Virtually every other comment I make I think would be in support of the conclusions I just mentioned, so those are my formal conclusions. I may have to add others as we have our conversation.

**Q.** Do you intend to give some opinions if you're called to testify in court as to those conclusions?

**A.** Yes.

**Q.** Are there other opinions you intend to give if you are called as a witness in court?

**A.** Those opinions cover a wide territory, so I wouldn't say I'm going to be limited in any narrow sense to them. There's really an additional amount of corroborating evidence that goes into making those opinions. So if we include all of the evidence from the psychological testing, from the interaction with Mr. Carson, you know, other related conclusions to those major conclusions may emerge.

**Q.** I want to ask you about — some questions about what we lawyers call causation. And legal causation may be something different from what psychologists and psychiatrists and medical people, health care professionals talk about, but — so we'll have to kind of see if we're talking on the same wave length. And what I'm really getting at is, I'm trying to find out what you're going to say at trial about your opinions and reasons for those opinions.

So let me ask you, do you have any opinions, or intend to express any opinions at trial as to the cause of any of these things, for example, the Paranoid Personality Disorder, the depression, the Anxiety Disorder?

**A.** Yes.

MR. WARREN: Object to the form of the question as vague, ambiguous, it's compound.

**Q.** I'm just trying to get a general idea if I should ask you about these things. Sounds like I should.

**A.** Yeah. Let's try one more time. Could you clarify, explain what you mean by these things, and then maybe I can clarify.

**Q.** For example, his depressive disorder; do you have any opinion as to what he's feeling that way now?

**A.** Yes.

**Q.** What causes it?

**A.** Yes.

**Q.** What is that opinion?

**A.** It's my opinion that Mr. Carson has depressive symptoms from a number of causes.

**Q.** Could you tell us what those causes are?

**A.** Yes. He has suffered some major disappointments in his life. And he is especially sensitive to having his opinions and beliefs about matters that are important to him, to have those opinions validated. And when the requests that he made to the city council were rejected, I believe he was profoundly disappointed by that and it affected his self-esteem and contributed to his feeling depressed.

**Q.** Is there anything else that contributed to it?

**A.** Yes. Mr. Carson uses certain self-protective psychological defense mechanisms. By that I mean everyone, Mr. Carson included, uses psychological defense mechanisms to deal with stress, handle pain, and to navigate in the world. When people's defense mechanisms don't work effectively, they are more liable to distressing emotional experiences, especially depression and anxiety. So another cause or Mr. Carson's depression, depressive symptoms, is that his habitual defense mechanisms are not working sufficiently to contain his stressful life experiences.

Other contributing factors could be — I can't say with certainty, but it's very common for people with back problems

to have some depressive symptoms. If they feel some restriction in their freedom of movement, it's not uncommon to be depressed about a loss of function. I can't evaluate to what extent that plays a role. I'm just saying it may be one factor. Mr. Carson is not working full-time, whereas previously, I believe, he was employed full-time. The lack of full-time employment for many professional people like Mr. Carson is depressing because it removes a source of competence and well-being.

Mr. Carson complained in the interview situation with me that he was suffering from some sexual dysfunction. That sexual dysfunction can cause depressive symptoms. If I could pull this together, what I'm saying is that depression is a symptom. It's a kind of a final common pathway caused by multiple different concurrent events, experiences, and feelings.

**Q.** I notice you did not mention his arrest of May 30th 1997. Is it your opinion that his arrest was not a substantial cause of his depression?

**A.** MR. WARREN: Objection, calls for a legal opinion, lacks foundation.

THE WITNESS: Could you restate the question, please.

**Q.** Yes. I noticed that you didn't say anything about his arrest during May of 1997, at the city council meeting. Do you think that was a cause of his depression as you've diagnosed it?

**A.** I believe that the arrest was one of a number of disappointments and embarrassments that Mr. Carson suffered, and as one of the disappointments or embarrassments that he suffered, it could enter into — could be a factor in his depression.

**Q.** It could be a factor. Do you think it probably was?

**A.** I'm saying it could have played a role. How much of a role is very difficult for me to determine at this moment.

**Q.** Can you say it was not a cause of his depression?

**A.** No.

**Q.** It cannot be ruled out as one contributor to depression?

**A.** I don't think —

**Q.** It sounds like you're saying as far as the arrest during May of 1997, you don't have any opinion one way or the other whether that caused or did not cause his depressive disorder that you believe him to be suffering from.

**A.** MR. WARREN: Objection, misstates his testimony.

THE WITNESS: Can you rephrase the question, please.

**Q.** What I'm trying to get at is what opinion you have as to the role the arrest back in May of 1997 played in bringing about his depression. And it sounds to me like you said you don't know if it did and you don't know if it didn't. But I just want to make sure. Can we say, then, you don't have any opinion one way or the other?

**A.** MR. WARREN: Objection, vague and ambiguous, calls for speculation, lacks foundation, misstates his testimony.

**Q.** Do you have any opinion as to whether or not Mr. Carson's arrest in May of 1997 was a cause, be it in whole or in part, of his depression that you consider him to be in?

**A.** Could you clarify further what you mean by was a cause either in whole or in part?

**Q.** Well, I don't know how. I'm not sure how clear I can get. The California Supreme Court in one case talked about throwing a match into a raging forest fire. They're discussing causation. And what they kind of imply, that's not a substantial cause of the fire that moves on and burns down somebody's house.

**A.** And I think what I mean in this question is, is it a causation that's significant. The law sometimes talks about a substantial cause, and it doesn't define what substantial is. But the law does say it's something not trivial and kind of lets it go at that. So I'm trying to figure out what you think, what role you think his arrest back in May of 1997, what role that played in the cause of his current state of depression.

MR. WARREN. Object to the form of the question. It calls for a legal opinion or conclusion beyond the expertise of this witness.

**Q.** Do you have an opinion as to whether or not Mr. Carson's arrest in May of 1997 was a substantial cause of his condition of depression at the current time?

MR. WARREN: Objection, calls for legal opinion beyond the expertise of this witness and it's vague and ambiguous as to substantial cause.

**A.** Could you clarify further what you mean by substantial cause, and maybe we can get clarity on that and I'll be able to answer it.

**Q.** If Mr. Warren were to ask you that question and say, Doctor, do you have an opinion as to reasonable degrees of medical

certitude whether or not the arrest of May of 1997, was a substantial cause of Mr. Carson's current state of depression, would you be able to answer that?

**A.** MR. WARREN. Objection, calls for speculation. It's vague and ambiguous, seeks legal opinion. Object to the form of the question.

MR. GRIFFITH:

**Q.** Very often that's the way lawyers ask these questions. The reason I'm asking, If he had never been arrested back in May of 1997, do you have an opinion whether he would be suffering the exact same symptoms of depression that you saw him with recently?

**A.** Exact same symptoms of depression? Are you asking hypothetically if we could magically remove the arrest from these life events, would all of the prior life events and his reaction to them that I've mentioned be sufficient to cause depressive symptoms?

**Q.** To the extent you believe he suffers from those symptoms at the current time.

**A.** Yes, I would answer yes to that.

MR. GRIFFITH:

**Q.** So could we conclude, then, that the arrest doesn't really play any role in his depression?

MR. WARREN: Objection, calls for speculation.

THE WITNESS: Could you restate that question, I think it's 60/40 or even 51/49 percent probable, then that's — I think I'm leaning that way. It's a little more likely than not. That's what I mean by probable. Possible, of course, anything is possible.

**A.** Right.

**Q.** So that's the context I'm using. By probable, I mean more likely than not.

**A.** MR. WARREN: Well, there are a couple of definitions you've offered for probable. I'll object to the form of the question as vague and ambiguous.

MR. GRIFFITH:

**Q.** All right. Mr. Carson is suffering from a condition of depression, correct?

**A.** That's correct.

**Q.** I probably am not, I think. And I want to know why he is and I'm not. So what I'm asking is what do you think probably caused his condition of depression. By that I mean I'd like you to eliminate mere possibilities, things that you say I can't tell one way or the other or it could, but I have no evidence to support it. Those are possible causes. Those type of things are what the law calls speculation. We're talking about who do I think is probably outside that door. I could guess, but I wouldn't really have any basis for making that deduction. But if I heard my wife out there and she said, "George, are you in there?" So when I use the word probable in this context, in this deposition when I say something is probable or it's probably so, what I mean is that it's more likely than not. And if you don't know or have no information upon which to build a hypothesis or other logical progression of inferences, I'd like to eliminate that.

**A.** MR. WARREN: Just a moment, sir.

MR. GRIFFITH:

**Q.** Mr. Carson might have had some episode that he never told you about. Well, it's a possible thing he was hit by a car on the way over–or scared by a car on the way over to my office, and maybe that caused it. But that's not probable. It's not more likely than not. So when I talk about probable cause, I talk about a cause that is more likely than not. Do you think you're able to give an opinion as to the causation of Mr. Carson's condition of depression?

**A.** Could I read a conclusion from my report that I think answers your question?

**Q.** Yes.

**A.** I concluded in my report that Mr. Carson suffers from Anxiety and Depressive Disorders N.O.S. I said these conditions are a result of his feelings of failure and humiliation about not the city council to adopt his ideas, plans, and remedies. That constitutes one contributory cause in my view to his depression.

**Q.** So he made some suggestions to city council; isn't that correct?

**A.** That's right.

**Q.** And what is your understanding what those suggestions were?

**A.** I'd have to have the actual record in front of me

**Q.** He made some suggestions about safety for community buildings. Do you have any recollection of that?

**A.** I don't remember the exact facts about that.

**Q.** Well, he appeared before the community board a number of times about safety. Is that your understanding?

**A.** I don't recall the details about it. What I'm testifying to is my understanding that suggestions and opinions and recommendations he offered were rejected in a number of areas.

**Q.** What were his recommendations, as you understand, that were rejected?

**A.** I believe recommendations about the trash around his property.

**Q.** Do you know what that recommendation was?

**A.** I don't. I'd actually have to see the record.

**Q.** What record are you speaking of?

**A.** I'm using my recollection of Dr. Levy's report as from the records that he reviewed. So I'm assuming that he correctly summarized certain aspects of this in his report.

**Q.** Do you have a copy of his report with you?

**A.** I don't.

**Q.** I have a copy here.

**A.** That would be helpful.

**Q.** He gave it to us this morning. Maybe you could take a look at it and see if that refreshes your recollection.

**A.** Okay. Yes, It says here that his suggestions, proposals, and petitions were rejected by local government agencies.

**Q.** And what is your understanding that his rejected recommendations were?

**A.** I'm assuming that the description offered by Dr. Levy is an accurate description in his report. The ideas, proposals, and suggestions were generally neither accepted nor adopted by the city council.

**Q.** Actually they did make some changes he suggested. Is that your understanding?

**A.** I don't know about that.

**Q.** Would that change your opinion any if you knew that they had, in fact, made some changes he suggested?

**A.** My opinion is based on his experience of cumulative disappointment in not having his suggestions and proposals and petitions accepted. The testing shows that he is extremely vulnerable to injuries to his self-esteem, that the condition he suffers from, a Paranoid Personality Disorder with narcissistic traits or features, that type of individual is extraordinarily sensitive to not be validated and admired.

So the evidence from the tests ties in with the life experiences to contribute to an impression that for Mr. Carson who is extraordinarily sensitive to having people disagree with him or dismiss him or not accept his viewpoint, that a number of public rebukes and rejections of the kind he experienced would contribute to lowering his self-esteem which would then contribute to depression.

MR. GRIFFITH:

**Q.** What I'm saying here, you're making — you're basically including at least in part an assumption that he made certain recommendations to the city and his recommendations were rejected. Am I correct in stating it that way?

**A.** What I assume from Dr. Levy's report is that a number of suggestions and proposals and petitions were made, and that Mr. Carson would be extraordinarily sensitive to having any of his proposals rejected. What I'm giving an opinion on is that Mr. Carson is an individual who desperately needs other people to accept his opinions and recommendations and that he's particularly vulnerable to drops in his self-esteem causing depression when his opinions are not agreed with.

**Q.** Just something that's been his characteristic for a long time?

**A.** Yes.

**Q.** So how often did he get depressed before 1997?

**A.** I can't answer that.

**Q.** Do you know of a single instance when he did?

**A.** I have no information about that.

**Q.** So you made some — you stated several things. You'd have to weight all these things?

**A.** Yes.

**Q.** If the city went out in front of your house and changed the grade of the street and it caused considerable flooding to your property, would that bother you at all?

MR. WARREN: Objection to the form. It's hypothetical.

THE WITNESS: Could you restate the question.

**A.** I'd have to know all the facts of the situation about what produced what. I'd have to know all of the specific facts that pertain to a particular situation.

**Q.** Would you agree that under certain circumstances that somebody in Mr. Carson's position where the city did cause water to flow onto his property, would you agree that it would be reasonable under some circumstances for somebody like Mr. Carson to be upset with the city?

**A.** MR. WARREN: Objection, calls for speculation, ambiguous as to certain circumstances.

THE WITNESS: Could you try again to restate the question.

MR. GRIFFITH:

**Q.** Yeah. To me it doesn't seem unreasonable at all. If somebody flooded my property, I'd be upset about it. Does that seem weird to you?

**A.** MR. WARREN: Objection. It's vague and ambiguous.

THE WITNESS: I'd have to know all the facts.

MR. WARREN: Excuse me, I need to get the objection on record. If it's intended to be a hypothetical, it's incomplete, lacks foundation.

MR. GRIFFITH:

**Q.** What facts would you need to know?

**A.** The facts I'd need to know are what the circumstances were regarding the flooding, I'd need to have, you know, a documentation of the actual extent of the flooding. I would need to know the pre-existing personality of the person whose property is being flooded to determine how that individual would react. There could be a very wide range of reactions depending on someone's personality.

MR. GRIFFITH:

**Q.** Do you have any information as to the circumstances regarding the flooding of Mr. Carson's property?

**A.** Only summary statements that pertain to it that might have appeared in Dr. Levy's report. If that was discussed in there, then I at least read it in draft form.

**Q.** Was that information enough for you to determine whether it was reasonable or not for Mr. Carson to request that the sidewalk in front of his house be raised?

**A.** I can't offer an opinion about that.

**Q.** You don't know?

**A.** I have no opinion about that, whether it was reasonable for him to ask that the sidewalk be raised.

**Q.** That's because you don't have enough information?

**A.** No, I don't have enough information.

**Q.** And you don't have enough information to determine whether it was reasonable or unreasonable for him to ask them to change the drainage pattern; correct?

**A.** That's correct.

**Q.** What other factors do you take into consideration? You said major disappointments. Reading Dr. Levy's report, what are some other major disappointments do you think entered into this?

**A.** I'll refer actually to my own report. Yes, the fact is enumerated on page 3, second paragraph, about the middle of the paragraph where it says, "numerous stressors are all contributing to a state of overload, including but not limited to a back injury, number one. Number two, disappointment in having his suggestions and opinions rejected by the city council. Three, feeling humiliated by the arrest. Four, irrational fears of being harmed by the police. Five, the stress of litigation.

**Q.** Are you saying that after he was falsely arrested and traumatized by the experience and that an arrest of somebody that's never been arrested before is not a contributing factor to his depression, is that what you're saying?

**A.** No.

**Q.** How did you come to that conclusion?

**A.** I came to that conclusion by reading the summary of the description of what transpired during the arrest as detailed in Dr. Levy's report.

**Q.** He was handcuffed?

**A.** It's my understanding he was handcuffed, taken to the police station. He was there for an hour. He appeared calm during the time that he was there. He did not witness anyone being physically abused. He was not physically harmed. He was composed enough to write a statement, and he was released on his own recognizance. That's my understanding.

**Q.** Well, did you take into consideration any effect this may have had on his belief structure? For example, the way the world is supposed to work?

**A.** MR. WARREN: Objection, vague and ambiguous. Object to the form.

**Q.** Did you reach the conclusion that he had a very strong belief in the way the government is supposed to work?

**A.** MR. WARREN: Same objection. Vague and ambiguous.

**Q.** What experience do you have with people being arrested and the effect on their psychological condition?

**A.** The experience of the times it's come up in forensic evaluations, and occasionally as it's come up in doing psychotherapy.

**Q.** How has it come up in forensic situations?

**A.** That people are arrested, like Mr. Carson, for a wide variety of causes, and their reaction to the event depends a great deal on their personality and their belief system prior to the event. So the same event, an arrest, has different effects depending on the personality and emotional and cognitive functioning of the individual who is arrested.

**Q.** And can it sometimes result in depression?

**A.** Could you make that less hypothetical and more specific?

**Q.** Well, you've indicated, if I understand you, that people are arrested, and some people it affects a lot, some people it doesn't affect; is that right?

**A.** No. I wouldn't say that. I'd say that there's a broad range of reactions to an event.

**Q.** Ranging from what?

**A.** It's hard to answer that. Ranging from literally the entire spectrum of behavioral reactions, because people are so individually different with regard to how they deal with stressful events.

**Q.** What would be the worst reaction?

**A.** Now, can you make this less hypothetical?

**Q.** I'm saying whatever range you have in mind when you said that the reaction to an arrest ranges all over the place.

**A.** Along what dimensions does it range?

**Q.** Right. I'm trying to say what can happen to somebody? How far does it go?

**A.** Some people can get, as in any stressful event, very anxious. Some people remain fairly calm. Some people would get frightened about what might happen. Other people might not. So the range is extremely broad.

**Q.** So some people might not get anxious at all; is that correct?

**A.** That's correct.

**Q.** Other people would get anxious, fearful?

**A.** Yes. There could be other dimensions as well.

**Q.** How bad a psychological effect could an arrest have on somebody?

**A.** For some people it could be devastating.

**Q.** What would make that devastating for some people and not for others?

**A.** You know, we're in such hypothetical territory, these questions are very difficult to answer. Can you try and make it more specific with regard to this case, because I think that will help me answer your question.

**Q.** My question now has to do with what you said to me about there's a whole range of reactions. Now, you've mentioned somebody could be fearful and anxious. I'm saying does it ever get any worse than that, or is that about all that ever happens to somebody that gets arrested?

**A.** It goes — I mean, people have a full range of reactions. Some people become extremely disorganized in their thinking and have a psychotic episode.

**Q.** Have you ever heard of that happening?

**A.** Yes. What kind of a case? What were the circumstances of the arrest? You know, it's — now I'm relying on cases that are just generally written up in the psychological testing literature. And, you know, it's well-known that there are some people who are predisposed to have a psychotic episode for whom that could tip them over the edge. And, you know, incarceration can be extremely frightening.

**Q.** Do you think Mr. Carson was frightened by being arrested and incarcerated?

**A.** Yes, I do.

**Q.** Do you think that it could have tipped him over the edge?

*COMMENT:* The attorney is not managing the deposition well; he spends too much time of lines of inquiry that don't go anywhere, he has not found any way to challenge my opinions and he is relying too heavily on hypotheticals that have little relevance and are easily discounted.

**A.** The "it could have" part is not clear. Can you make the question more specific?

**Q.** Yeah. I'm focusing on your statement in your report that the arrest was of minor influence as a contributor to the disorders he suffers from. You've given me an example where far from being a minor influence, an arrest could tip somebody over the edge. I'm saying what makes you think it didn't happen to Mr. Carson?

**A.** Because I think he was suffering from the mental disorders I listed prior to the arrest.

**Q.** Once he was suffering from these mental disorders, the arrest just couldn't make it any worse?

**A.** No, I wouldn't say it couldn't make it any worse, but that it was not the principal cause of those disorders.

**Q.** Why do you say it was not? In other words, how do you distinguish the arrest from those other causes?

**A.** The test data suggests that Mr. Carson is the kind of person who needs, requires, demands great acceptance of his beliefs and opinions and ideas, and that prior to the arrest he had already suffered a blow to his self-esteem. The injuries to his self-esteem that he suffered were already occurring prior to the arrest. And so the arrest is now an additional influence on an already pre-existing set of causes that have already been set in motion.

**Q.** It occurs to me that maybe somebody that's in that condition, the arrest might be really traumatic, where somebody who was not in that condition, might not affect them that much. Is that — am I just totally off base in thinking along those lines?

**A.** That's not my conclusion. I don't think that the arrest was traumatic. I think Mr. Carson may believe the arrest was traumatic, but that doesn't make it so.

**Q.** Is Mr. Carson going to react about what he believes or what you believe?

*COMMENT:* Of course Mr. Carson is going to react to what he believes–but just because the plaintiff's believes it doesn't make it so, and it certainly doesn't entitle him to recover for damages. The deposing attorney needs his own experts to provide clear and convincing evidence that (1) the plaintiff was injured and it met the event criteria for PTSD; (2) that the psychological injury was proximately caused by the event. In addition, the deposing attorney needs to find some way to challenge my opinions at trial; in order to mount an effective cross-examination he needs to elicit a different kind of information–not hypotheticals–but a way to challenge my data, my methods and my conclusions.

**A.** MR. WARREN: Objection, calls for speculation.

THE WITNESS: Could you restate the question, please.

MR. GRIFFITH:

**Q.** What is it that makes you think the arrest was not traumatic?

**A.** I define a trauma, as in PTSD, as a life-threatening event.

**Q.** Let's not focus on PTSD Do you think that as long as somebody who is arrested is not threatened with their life, that doesn't affect them very much?

**A.** There's a wide range of reactions, as I suggested.

**Q.** So why do you think this was not a traumatic event for Mr. Carson? And I'm not focusing on PTSD

**A.** MR. WARREN: Are you referring now to the statement in the doctor's report on page three that you referred to earlier? Is that the basis for the question?

MR. GRIFFITH: No.

THE WITNESS: I think it was an anxiety-provoking event.

MR. GRIFFITH:

**Q.** But you're saying it is not traumatic?

**A.** That's correct.

**Q.** Can a divorce be traumatic?

**A.** MR. WARREN: objection, calls for speculation.

**Q.** THE WITNESS: Can you make that more specific again?

**A.** MR. GRIFFITH:

**Q.** Well, when you — I'm trying to find out what you mean by the word traumatic.

**A.** I'm in the territory of post-traumatic stress disorder in using that term.

**Q.** You said he doesn't have that?

**A.** That's correct.

*COMMENT:* Counsel next changes the subject. It would have been more effective if he had continued with this line of questioning. A large portion of this case rests on whether the plaintiff had a traumatic reaction to the arrest; if there is no trauma then by definition there is no PTSD and no proximate causation upon which a claim of damages can be made. This is a key issue and the deposing attorney is losing a major point.

**Q.** Let's talk about something else. Let's talk about depression. In the context of depression you don't think the arrest was traumatic, correct?

**A.** There's something too exclusionary about the form of your question. Can I restate it, and maybe this will help.

**Q.** Sure.

**A.** You're asking me do I think the arrest played a relatively minor role in his depression. Would that be a fair statement of the question or another way of stating it?

**Q.** Well, I think we're talking about something a little different. I understand that you don't think it played a big role in his depression.

**A.** That's correct.

**Q.** And I'm trying to find out why not. I've represented people who have been arrested by the police before, and invariably they say that was the single most important event in their life. Have you ever heard anybody say that who was arrested?

**A.** MR. WARREN: I'm going to object to the question in terms of its foundation, in terms of even its relevancy to this lawsuit. I think there are at least two questions out in that last phraseology.

THE WITNESS: Could you separate the questions, please.

MR. GRIFFITH:

**Q.** Yeah. Have you ever heard anybody — have you ever treated anybody who's been arrested and they claimed it caused a problem for them?

**A.** MR. WARREN: Objection, vague and ambiguous.

THE WITNESS: Can you make it more specific still.

MR. GRIFFITH:

**Q.** Yeah. Anybody you ever examined indicate to you that they were arrested and that that arrest caused any kind of anguish or psychological impairment?

**A.** I can't recall a specific person, but over more than 20 years of practice I have a vague recollection that at least one person

I saw was arrested and upset by it. That would not be an unusual occurrence for some people. But the range of reactions to being arrested is enormous.

**Q.** You mentioned you considered Dr. Levy's report in concluding that these major disappointments affected Mr. Carson.

**A.** Yes.

**Q.** Dr. Levy mentioned his request to raise the sidewalk, changes to the drainage system, make repairs to his house. When is your understanding that Mr. Carson's symptoms of depression began?

**A.** MR. WARREN: Object to the form of the question. One, it assumes that there's only been one onset of depression as opposed to multiple onsets or multiple episodes. So lacks foundation.

THE WITNESS: I can't pinpoint it.

MR. GRIFFITH:

**Q.** Do you have any idea at all?

**A.** Really I can't pinpoint it. It's a very difficult question to answer without my reviewing in great detail the exact history.

**Q.** Let's look at the results of DSM-IV testing. Can you tell us what the symptoms of depression—Depressive Disorder N.O.S. as you called it, what those symptoms are, what the factors are. Does DSM-IV identify symptoms or establish criteria for a diagnosis, Doctor?

**A.** Yes.

**Q.** They establish criteria for a diagnosis?

**A.** That's correct. The criteria for Depressive Disorder N.O.S. include disorders with depressive features that do not meet the criteria for major Depressive Disorder or other specific mood disorders.

**Q.** Is there anything else? Does it go on?

**A.** It gives an example of the kind of disorder that they're referring to, and it would be something like criteria number three, depressive episodes lasting from two days up to two weeks occurring at least once a month for 12 months.

**Q.** Did Mr. Carson meet that criteria?

**A.** Hold on a second. I'm not prepared to testify to that specific criteria, but more what the general intent of the category is.

**Q.** What criteria does he meet?

**A.** He meets the criteria of having depressive symptoms that constitute a functional impairment and that are subjectively distressing.

**Q.** What function — what functions are impaired?

**A.** Hold on a second. The function of sleep.

**Q.** Okay. Anything else?

**A.** Sexual function.

**Q.** Okay. Anything else?

**A.** The capacity to regulate self-esteem. Is that clear?

**Q.** No, actually it's not. This is a result of the depression, the inability to regulate self-esteem?

**A.** The problems with self-esteem are both a cause and an effect of depression, so they're very much involved in depression, and they're very much involved in Mr. Carson's problems. What the testing suggests is that Mr. Carson is the kind of individual whose self-esteem fluctuates very markedly and that he is especially susceptible to a loss of self-esteem, to an injury to his self-esteem when things don't go his way. Things have not been going his way for some time.

Therefore, I am presuming, given that sensitivity, that depression is a natural occurrence of what he experiences as failures and frustrations and disappointments in a variety of areas.

**Q.** Well, he has this fragile self-esteem?

**A.** That's correct.

**Q.** So could we expect, then, that he's experienced periods of depression going back several years beyond — in other words, earlier than his arrest? So what you're saying, from your testing you conclude he probably was depressed long before his arrest?

**A.** That's correct. Mr. Carson may be the kind of individual who if he suffered reversals, disappointments of an important kind would that lead to depression, and I'm saying yes. I am concluding — or I'm inferring would be more accurate to say, given Mr. Carson's personality, that major disappointments and blows to his self-esteem prior to the arrest would be likely to induce a depressive affect.

Maybe this will help clarify something. There's depression as an affect or as an emotional state, and there's depression

as a clinical entity. So what would be the most accurate way to describe this would be that Mr. Carson, given the narcissistic trends in his personality, has rapidly fluctuating self-esteem and a predisposition to experience depressive affect or emotion when he is disappointed. Assuming he suffered significant disappointments prior to the arrest, that's my assumption, I would also assume that he will experience depressive affect of a kind that could contribute to a depressive condition.

**Q.** If you learned that he did not experience this depressive effect before his arrest, would that change or influence in any way any conclusions you would draw from your tests?

**A.** It's not clear what you mean by learned. He did not experience — I mean, you have to really specify.

**Q.** You haven't checked to see whether he was experiencing depressive affect or any other type of depression before his arrest; am I correct?

**A.** I'm inferring that — without going to the primary record itself, I'm inferring that there are certain summary statements, particularly from Dr. Levy's report.

**Q.** Suppose you went out and checked yourself, and you couldn't find any evidence that he ever experienced depressive affect or periods of depression before his arrest. Would that change your interpretation of the tests?

**A.** No, it wouldn't change. The tests stand on their own.

**Q.** It wouldn't change your conclusions that you drew from the tests?

**A.** That's a different matter.

**Q.** Would it?

**A.** You'd have to tell me the specific facts in evidence which — then I would try and relate to the conclusions drawn from the test. It's very hard to talk about this in general terms.

**Q.** Do you think his back injury several years ago was of minor influence as a contributor to the disorders he suffers from?

**A.** I can't make an opinion about how minor or major it was. I'm just assuming that it could be one factor. And from my experience, which is fairly extensive, with individuals with back problems, that they often do experience depressive symptoms occurring.

**Q.** You mentioned — in the report you mentioned his being passed over for work at his job and working part-time. Where did you get the information that he was passed over at work?

**A.** That may not have been exactly the correct description, but that idea that he was either not getting certain jobs or working assignments he would have liked to have came from that comment in Dr. Levy's report.

**Q.** Did you assume that to have taken place before his arrest?

**A.** No.

**Q.** What tests did you give Mr. Carson?

**A.** The test list is on page 2. The Rorschach Inkblot, the Millon Clinical Multiaxial Inventory, individual subtests of the Wechsler Adult Intelligence Scale, third edition, TAT Test, and the Brief Symptom Inventory.

**Q.** With the Rorschach Inkblot test you show him some pictures?

**A.** Inkblots, correct.

**Q.** Do you have those inkblots with you?

**A.** No, I do not.

**Q.** And I need to get a copy of those. How can I get those and have them copied?

*COMMENT:* Counsel is showing his lack of preparation for this deposition. He has little idea about what the Rorschach inkblot test is, even though his own expert administered the same test. He obviously has not consulted with his own expert about his own expert's testing. The attorney is unprepared to examine my findings because he doesn't really understand what the test is designed to find out. He wasted a lot of valuable time in the deposition having me educate him about the Rorschach inkblot test — he should have done this preparation with his own expert.

**A.** They are — you've actually already got them in Dr. Johnson's [the attorney's expert's]'s report. He used the same test that I did, and the images are reproduced on a page called the location sheet. And my recollection is that that was included in the information that you gave me. I could make a copy of that same sheet, but you literally have the exact — from looking at Dr. Johnson's the exact same test I did.

**Q.** Doctor, can I ask you this. Is the material you used in the Rorschach test a standardized series of inkblots which you have identified in your report as RIAP4?

**A.** No. The Rorschach, there are two things there. RIAP4—That's the scoring program.

**Q.** Is there a text which you can identify as containing the series of inkblots that you used to administer this test to Mr. Carson?

**A.** Yes.

**Q.** Would you do that — what did you use?

**A.** Any psychological tenting book that reproduces what is called the location sheet shows miniaturized pictures of all of the ten inkblots. It's available in multiple textbooks. The inkblots themselves are a standard agreed-upon series of visual stimuli that everyone uses. There's only one set that's called the Rorschach Inkblot Test, and it's the same set that Dr. Johnson used and I used.

**Q.** That's called a location sheet?

**A.** It's called the Rorschach Inkblot Test series. There is — there are a series of ten cards published by various test publishers and widely available through them and reproduced in miniature form on what's called the location sheet. Which you have the location sheet in your possession. I certainly could easily provide that for you.

**Q.** What you used was something different from the location sheet; it was bigger pictures?

**A.** I used the inkblot test itself, which is the same test that Dr. Johnson used. It's the cards that are a little bit larger than a paperback book, ten cards. Those cards are then miniaturized and placed on one sheet for the purpose of scores.

**Q.** But as to the cards that you actually used to administer the test to Mr. Carson, you have those in your possession?

**A.** Yes.

**Q.** MR. WARREN: Counsel, do you want a copy of those?

**A.** MR. GRIFFITH: Yes.

**Q.** MR. WARREN: Excuse me, would you make copies of those, and would you send them to me, and I'll send them to Mr. Griffith?

**A.** THE WITNESS: We've run into a problem. The test, it's copyrighted. The cards are copyrighted, and I'm not supposed to reproduce the actual cards. I can reproduce — I can send you an original copy of the location sheet which produces each card in miniature.

MR. GRIFFITH:

**Q.** In color?

**A.** In color. I've got another location sheet. It's an exact replica; you would have the actual images that were shown to him, just smaller. The actual cards are copyrighted and we're instructed as psychologists to not reproduce them.

**Q.** What was the first card you showed him?

**A.** I don't have it with me.

**Q.** Do you know what it was?

**A.** Yeah. I mean, I can–they're very hard to describe because their ambiguous stimuli.

**Q.** Let me ask you, is there a means of identifying each of these ten standard inkblots by number or otherwise in the sequence that you administered this test to Mr. Carson?

**A.** They're just called by their card and numbers. There's no formal description of them.

**Q.** Is it card number 1?

**A.** Card number 1 through 10 administered in sequence—

**Q.** If I were to ask you did you show him in order 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.

**A.** Correct.

**Q.** What I'd like to do is ask you what his response was to each of the cards you showed him.

**A.** On page 5 of the RIAP Interpretative Report is a list of the responses to each card.

**Q.** You have something written there. What follows after that?

**A.** On page 13 I describe that Mr. Carson has a tendency to draw illogical connections between objects and events. And I give an example of his response on card 10, response 15, "some crabs may be dining on a fish or something," followed by what's called my inquiry, which means I ask him what specifically about the inkblot made it look like crabs dining. And the material produced in italics are a verbatim record of Mr. Carson's response to the inkblot. Or his response to my inquiry questions about what he saw in the inkblot.

**Q.** I have a question, sir. On page 13 of your report following the word inquiry that you have been referring to there —

**A.** Yes.

**Q.** Everything that follows that is in italics all the way down to the bold print at the bottom of the page, Axis I Disorders. Is all of that verbatim record of Mr. Carson's response?

**A.** No, it also includes my questions.

**Q.** Then would you clarify when you say everything in italics is verbatim from Mr. Carson.

**Q.** Thank you. Everything in italics either represents Mr. Carson's statements or my questions, which are followed by a question mark or sometimes his questions.

**A.** In the text, the italicized text, there's all these words that are in brackets, parentheses.

**Q.** What does that represent?

**A.** That refers to the particular — a particular area of the inkblot that he was referring to.

**Q.** Do you have something like that for each of the Rorschach inkblot cards —

**A.** Yes.

**Q.** In your report?

**A.** Not in my report. In the verbatim transcript of the test.

*COMMENT:* Instead of asking me questions that he can use later at trial to challenge my results, he is using the deposition for me to explain the mechanics of test administration and scoring instead of focusing on the much more important issue of the evidence I used from the test to draw the conclusions that I did. If he had used his own expert properly, he would have come to the deposition ready to elicit the key material he needs for trial; instead he got information that is available in any textbook and he lost a valuable opportunity.

**Q.** I am wondering what's the best way to work this. You've said what his response was, and you made some inquiries, and he's responded. The two of you are talking back and forth at this point in the test; is that correct?

**A.** Yes.

**Q.** Did you make any notes as you were going along as to what your conclusions were?

**A.** No.

**Q.** You just wrote down the responses and what the inquiries were?

**A.** Yes.

**Q.** Actually, what I'd like to do would be to recommence the deposition at another time to continue on with this with the actual cards or the — what do you call it, the ledger?

**A.** Location sheet.

**Q.** Maybe we can proceed a little more. I'm wondering it there's a more expedient thing we can do which is — when that information is available to you, it's going to be quite time-consuming to go through the entire test like that. I wonder if it would allow us to complete our deposition today, is if you

asked me what conclusions I drew about Mr. Carson from the testing, because that's really what's material in the case. And I could answer that from the material in my report in which I give all of the evidence that I'm using. So in other words, the material conclusions I'm drawing from the Rorschach are in this report with the evidence. I think there's a chance you can get the information you need if you actually ask me what conclusions I drew from the test, because I could give you the foundation for it.

**Q.** Do you have any other items in your file that you brought with you here today?

**A.** Yes, I brought two scoring manuals.

**Q.** And these are what? Will you tell me what they are and what edition, if there's an edition?

**A.** Yeah. So each one of these goes with one of the tests, so let's be clear about it. The MCMI-3 manual, second edition is the manual for interpretation of Exhibit 4.

The Brief Symptom Inventory manual is the manual for the interpretation of Exhibit 7. Obviously I relied on these.

**Q.** Anything else you have with you?

**A.** No.

**Q.** What are the duplicates you have there, Doctor?

**A.** The duplicates are the MCMI.

**Q.** I just want you to check that you haven't omitted something that is not a duplicate.

**A.** No, I'm sure that I've got all the tests.

**Q.** Okay. Let me ask you about the Rorschach test. You showed him some inkblots, asked him what he saw, made some inquiries, and had some discussion about each one, and asked him to point out where the feet of the crab were and things like that?

**A.** Yes

**Q.** And from that you made certain conclusions; is that right?

**A.** That's correct.

**Q.** Tell us about the Rorschach test in your own words and what your conclusions were.

**A.** The Rorschach test is administered by showing Mr. Carson ten standard inkblots which are ambiguous, and Mr. Carson

tells me what they look like to him, and I inquire what about the inkblot made him come up with the response that he did.

**Q.** Now, would you agree that in administering and interpreting the Rorschach test that it involves a good deal of judgment on your part?

**A.** The scoring of the inkblot test definitely involves judgment.

**Q.** What did you find significant, and what were your conclusions?

**A.** I concluded that Mr. Carson is prone towards disturbances in thinking, language, and logic when he is in an unstructured and emotional situation like the Rorschach.

**Q.** Did you reach any conclusions as to how long that disturbed thinking has been with Mr. Carson?

**A.** No.

**Q.** Is it something you would expect to have been there for many years or a shorter period of time? By many years I mean more than ten.

**A.** I'd need a lot of evidence.

**Q.** No way to tell on just the evidence you have at this point?

**A.** I wouldn't say there's no way to tell from all the evidence that's available to me, but it's not that I have at this moment.

**Q.** Anything else you found significant?

**A.** Yes, he has a tendency to confuse words and condense different words into single words that are indicative of problems in logic and language. For example, on card 2, response 5, he saw a microencephalitic baboon. A microencephalitic small head was the way he described it. He's actually condensing microcephalic and encephalitic into one word. When words are condensed like this, they get what's called a special score on the Rorschach. It's called a deviant verbalization because of an illogical word being formed.

This response was representative of a number of responses that occurred on the Rorschach where he engaged in strained logic or made words up and did not show that he understood that he was making a word up. So it represents a kind of disorder of thinking that's of concern.

**Q.** So people that use words like insenuendo or irregardless, would that be an example of that?

**A.** The first one insenudendo yes; irregardless, is more common.

**Q.** The Mayor of Chicago talks about insenuendo.

**A.** If he were referring to the Rorschach, it would be a deviation. Deviant language is a very sensitive indicator of subtle disturbances in the thinking process, and the Rorschach is an exquisitely effective instrument for picking up small deviations in language use of the kind that he shows, and that is of some concern.

**Q.** Okay. Any other significant things you concluded or noted?

**A.** Yes. This is a general conclusion put together from, you know, looking at a number of different tests, which is that he has a tendency to expect, seek out and at times, imagine malevolent forces. That kind of thinking is known as paranoid thinking, and its continued prevalence throughout the entire test sequence, all of the tests, is strongly supportive of a Paranoid Personality Disorder.

**Q.** Anything else with regard to the Rorschach test do you think is significant?

**A.** Yes. Mr. Carson's tendency to see aggressive interactions represents a projection of his own aggressive feelings onto the inkblot.

**Q.** Now, in reaching that conclusion what did you — what do you use to come to that conclusion?

**A.** This is detailed in the actual report how I came to this conclusion on card 8, response 13. He said he saw an Anklosaurus, an armored dinosaur, has horns or bony parts in its tail. He said that it has a big thing at the end of its tail, and then he says "you can imagine swinging it around and just clubbing somebody. So here we have an instance of a pretty ambiguous visual image that's being turned into a very dangerous dinosaur with a big thing on the end of its tail which he can imagine swinging around and just clubbing somebody. And this is an example of projecting aggression onto the inkblot test. And the significant instances of that are documented in my report, and when I rely on it, I quote.

**Q.** Would you say anything significant that you either noted or came to a conclusion is noted in your report? With regard to the Rorschach test I'm speaking of.

**A.** Yes.

**Q.** Is there a scoring manual for the Rorschach test?

**A.** There are scoring manuals and there is the RIAP computer scoring program of which you have the printout. The items

are scored as it — let's say their content, is it an animal or not. That's called a content. The scores are put into the program. The program crunches the data basically and comes out with an automated report that relates the specific scores he has to a database of thousands of Rorschach tests that are known to be collected from various kinds of psychiatric disorders. And then certain correlations are made between the scores and the disorders that he has.

And that's all documented in the report so that the output of the Rorschach is in the report in addition to what's in the report as to the examiner. Some subjective clinical judgment is used to sometimes interpret the meaning of particular contents, and when that was relevant, I commented on that in the report.

**Q.** What about the MCMI?

**A.** The MCMI is a pencil and paper test that's computer scored. So basically I have nothing to judge about that. The test is–

**Q.** Nothing subjective about that?

**A.** There's nothing subjective. So that would be called an objective test in which his test responses are compared to a computer database.

**Q.** And what's the purpose of the test and the score?

**A.** To be able to locate his disorders with regard to what other people who have those disorders report about themselves. So, for example, he indicates he's quite anxious on the MCMI, gets a score that's like individuals who have significant anxiety disorders. And that entered into my conclusion in saying that Anxiety Disorder N.O.S. That's both in the MCMI report, and in my report I mention the evidence.

**Q.** What is the — what's the next one, the WAIS?

**A.** The Wechsler Adult Intelligence Scale. The WAIS asks — there are a number of different subtests. I did not administer every subtest. I administered a number of verbal subtests and one verb test.

**Q.** To find out how smart somebody is, basically?

**A.** To find out how they solve different kinds of problems in a highly structured situation. Mr. Carson is a very intelligent individual.

**Q.** Any other conclusions you reached from the Wechsler test?

**A.** There was one conclusion actually that I drew from Dr. Johnson's report. Dr. Johnson administered all of the

subtests which I did not do. And on one particular subtest called Picture Arrangement what was notable was that Mr. Carson scored very poorly on that test compared to exceptional performance in almost everything else.

**Q.** What do you think that means?

**A.** And that's a test of planning and anticipating in social situations. So it's indicative of — people who have some trouble drawing logical connections about social situations tend to perform more poorly on that test. And that was in Dr. Johnson's testing.

Do you want me to keep going with them? The Thematic Apperception Test is a test where a person is shown a series of cards of real people interacting. It's not ambiguous like the Rorsahach, but there's some ambiguity as to what the individuals portrayed are doing.

**Q.** Are these standardized?

**A.** Yes.

**Q.** Do you have those cards or those pictures with you today?

**A.** No, I do not.

**Q.** How many cards are there?

**A.** Now, unlike the Rorschach, these are easily described, so there's a conventional description of them which is listed in my administration.

**Q.** Those show the ones that you used?

**A.** That's correct.

**Q.** If I wanted to get some of these cards, could I get them from you?

**A.** Yeah. I mean, we've got the same problem. They're proprietary and Copyrighted and not supposed to be reproduced.

**Q.** Is there a location sheet?

**A.** No.

**Q.** Or something similar?

*COMMENT:* Counsel has finally, rather late in the deposition when he is running out of time, gotten around to some of the crucial questions about my evidence for drawing my conclusions. However, he is still hampered by his lack of preparation; he doesn't understand the tests well enough to raise critical issues.

**A.** THE WITNESS: No, because in this situation because the cards are so much less ambiguous, there are standard descriptions like boy with violin that are so clear that it's easy

to understand what it means, whereas with the Rorschach there's no such descriptions available.

**Q.** What does it take to acquire the cards and the Rorschach?

**A.** Oh, you have to be a licensed psychologist.

**Q.** So any licensed psychologist could obtain these?

**A.** That's correct.

**Q.** And that's true with respect to the ten cards for the Rorschach test as well as these cards that you're talking about now with a boy with a violin?

**A.** That's correct.

**Q.** Got any idea how much you'd have to pay for them?

**A.** They're not very expensive. And Dr. Johnson used the same cards. Again, his TAT and my TAT are the same ones, though we have administered different cards.

**Q.** What did you conclude from the TAT test?

**A.** I concluded from the TAT test, which is documented in my report On page 9 that he has a tendency to project suspicious motives into the cards. So I give the example on TAT card number 3, which is described as picture depicting a woman holding onto the shoulders of a man who wants to leave, and the story he told is in italics.

The significant part of the story is the way her eyes are made up. Plaintiff said: "It looks manipulative as if she is holding him back but egging him on," and I note that was my emphasis. I then go on to describe for this picture most people make up a story about a woman trying to restrain a man. What's particularly noteworthy, idiosyncratic about his story is her mixed motives, and her kind of sneaky, malevolent intent is the kind of thing that he's very ready to find in situations that have some ambiguity in them.

**Q.** Can we tell how long he's had this tendency or this readiness to find these things? In other words, can we tell if this is a recent development or it it's life-long?

**A.** It's unlikely to be recent. It tends to be characteristic of people when I describe something as a personality trait, characteristic, or disorder, by the word personality I mean a relatively characteristic, enduring, pervasive way an individual thinks, perceives, feels, and acts as opposed to an acute, temporary or immediate reaction.

**Q.** Do you think a traumatic event could cause that personality disorder?

*COMMENT:* This question shows a lack of preparation and knowledge about psychiatric terminology: a personality disorder is a long-standing condition that usually begins by adolescence or early adulthood. An acute episode like a traumatic event does not cause a personality disorder—it causes post-traumatic stress symptoms, which usually occur long after the personality disorder is in place. He then asks me for names of books about psychological testing and diagnosis and ends the deposition. He should have gotten the names of these books from his own expert, read them in advance of the deposition and have been prepared to challenge me on the key issues. He has wasted a good deal of time in this deposition and he is coming away empty-handed for trial.

**A.** MR. WARREN: Objection, vague and ambiguous.

**Q.** THE WITNESS: Could you be more specific?

**A.** MR. GRIFFITH:

**Q.** Well, let's say somebody's held hostage by a man with a gun for six hours. Could that result in a Personality disorder as opposed to, say, Post-traumatic Stress Disorder?

**A.** MR. WARREN: Object to the form. If it's intended to be a hypothetical, it's incomplete.

THE WITNESS: You know, it's one of those questions where there's so much context, it's very hard to answer.

MR. GRIFFITH:

**Q.** But it would be possible under the right conditions?

MR. WARREN: Calls for speculation, it's vague and ambiguous.

THE WITNESS: I can't answer it in this form.

**A.** This is the problem. A Personality disorder is a relatively enduring set of attitudes, feelings, beliefs, expectations. So by definition it's not reactive to an event, so we wouldn't usually diagnosis its onset following an event. Whereas typically it's the Axis I conditions like anxiety, depression, and Post-traumatic stress Disorder that tend to be reactive to an event as distinguished from personality disorders, which tend to be relatively more enduring.

**Q.** MR. GRIFFITH: Thanks. Do you have any more comments about the TAT test?

**A.** No.

**Q.** The Exhibit 7 is the Brief — what is it?

**A.** Symptom Inventory.

**Q.** What is that?

**A.** That's a checklist of psychiatric symptoms.

**Q.** Tell me briefly how the test is administered and how it's scored.

**A.** The test is composed of 53 questions in which the individual indicates how much they were distressed by what's indicated in the statement. Like nervousness or shakiness inside, how much were you distressed by it?

And he marks in this case a little bit.

**Q.** Little bit, somewhat–

**A.** Moderately, extremely.

**Q.** And then how is it scored?

**A.** Then this is hand scored with a scoring template that's placed over the items, and the items on each scale are collected and averaged to come up with a score. The score is then placed on a grid that represents. A template that's basically a database in which individuals who indicate a lot of a particular symptom are then located with — located on how normal or abnormal is that symptomatology.

**Q.** And what did you conclude from the scoring?

**A.** This is very straightforward. He shows more than average symptoms in the area of somatization, that means physical complaints; he shows obsessive-compulsive complaints; That means thoughts, feelings, and actions that he can't get out of his mind; he shows depressive symptoms; he shows anxiety symptoms. All of those he shows considerably more than average. He shows somewhat more than average in a number of other categories. He shows greater hostility than average. He shows greater phobic avoidance, phobic anxiety, that means irrational fears, than average. He shows slightly more paranoia than average and only a tiny bit of psychoticism, but that may not be — it's just barely above the normal line.

**Q.** And what do you think this means about him?

**A.** To put it in lay terms, he's pretty stressed out. This is a pretty stressed out individual.

**Q.** Is there any way to tell how long these stresses have been going? From the test itself, I mean.

**A.** The test is a snapshot, a cross-section in time.

**Q.** Could change a month or a year from now?

**A.** That's correct.

**Q.** And be totally different? You mentioned your conclusion was that he was suffering from Depressive Disorder and Anxiety Disorder?

**A.** That's correct.

**Q.** These are somewhat different diagnoses?

**A.** That's correct.

**Q.** Is there any overlapping?

**A.** Yes.

**Q.** Do you know of any good psychological book, any recognized book in your field of psychology or psychiatry that would be a good book to read about these Post-traumatic Stress Disorders?

**A.** Yes, DSM-IV.

**Q.** Anything besides that?

**A.** Yes. A book by Glen Gabbard, Psychodynamic Psychiatry in Clinical Practice the DSM-IV edition.

**Q.** Any other good book, or is that the —

**A.** There's so many. Principles of Rorschach Interpretation by Irving Weiner, 1999. It would be very difficult for a layperson to understand that book but possible with a lot of effort.

**Q.** Can you give me one more?

**A.** Disorders of Personality by Theodore Millon, I think 1996. It explains all the personality disorders; it discuss them in great detail and would really help an attorney understand some of the jargon that psychologists use, which I know can be impenetrable sometimes.

MR. GRIFFITH: That's all the questions I have.

THE WITNESS: Okay.

## § 716.05 Deposition by Plaintiff's Counsel of a Forensic Psychiatrist

The following is the deposition taken of Dr. Levy, the forensic psychiatric expert witness in the same case (this deposition was actually taken prior to Dr. Rosenberg's deposition). Unlike the prior deposition taken of a forensic psychologist in which findings were based primarily on psychological tests, the psychiatric expert performed an Independent Medical Exam (IME) which includes a clinical psychiatric interview as well as reviewing all pertinent medical and legal records in addition to the psychological testing. Thus, the attorney's approach is quite different. (All identifying

information have been changed to protect the privacy of the participants except for Dr. Levy the actual deponent and co-author of this chapter).

MR. GRIFFITH:

**Q.** Let me just run through this and see that we've got everything here at the deposition that we requested. Beginning on the second page, we requested that you bring with you to the deposition any depositions and deposition testimony transcripts; statements, written, recorded or otherwise; or interviews reviewed by you as a part of your review of any aspect of this case. Do you have any of those documents?

**A.** Yes, I have.

**Q.** Would you identify what they are, please.

**A.** [The expert lists his records].

**Q.** Okay.

**A.** Do you want to see them right now?

**Q.** If I can just take a quick look at them.

**A.** Okay, sure.

**Q.** I see this letter says here these documents were mainly culled from approximately 1500 documents from the plaintiff. You don't have 1500 documents, do you?

**A.** No, these are the documents I have.

**Q.** The statement's made saying that Mr. Carson opposed the plan decided on by the council board regarding retrofitting/rebuilding.

**A.** I know that, yeah.

**Q.** Because of earthquake safety?

**A.** Yeah, decided it wasn't worth the expense.

**Q.** That was what Mr. Carson Mr. Carson was–complaining about, it wasn't earthquake safe enough. That was your understanding?

**A.** Your question is what was my understanding?

**Q.** Yeah. Actually, I'm trying to get some idea of what additional information you may have other than the fact that he opposed the seismic safety plans that were being adopted by the council. And I'm asking are you aware that he might have been right?

**A.** Mr. Carson himself told me that he had opposed the seismic retrofitting —and that, in fact, they tore it down, decided that it wasn't cost effective to retrofit it properly.

**Q.** Mentioned that he claimed voter fraud. Did you get some information that, in fact, there was evidence of irregularities?

**A.** No, I did not.

**Q.** And he had a significant fight with the City alleging flooding of his property. Eventually he got the city to change the drainage. Did you know that?

**A.** I know the case was settled. He said they made some repairs and paid him a sum of money.

**Q.** And they apparently fixed the drains. Did you learn that also?

**A.** I didn't know what the repairs were, but I knew whatever it was satisfactory to him.

**Q.** He made numerous complaints to the Santa Barbara Police Department regarding residents of a city owned building in and around his home. Did you also have information that the police had told him to call them whenever he had problems?

**A.** I think he told me that, yes.

**Q.** These documents I have in my hand is what you're talking about?

**A.** That's correct.

**Q.** When you say miscellaneous additional documents, you don't mean anything in addition to this?

**A.** No. Everything else in addition I have detailed. That's what I'm referring to, this document, this package of documents.

**Q.** I'd like to make — if we could, I'd like to make your copy of the deposition notice as Exhibit 1. And these documents that you described in item 25 of your report on page 20, namely the miscellaneous additional items, I'd like to make those Exhibit 2. Would that be okay?

**A.** Yes.

**Q.** What I propose is we'll have the original marked, have copies made of those exhibits, then attach copies to the original transcript, returning the originals to Dr. Levy. And

we will be sure that Dr. Levy produces all documents at time of trial at the time he testifies.

**Q.** That's fine with me, yes.

(Whereupon, all of Plaintiff's numerous exhibits were identified and marked for identification.)

**Q.** If you'd like to turn to the page here that is dated Sunday, 3-26-00, 10:11 a.m., ending 3:26 at 11:02 a.m. Using this page, which apparently is some notes you took in a conversation with — who was that, Dr. Rosenberg?

**A.** Yes.

**Q.** Can you tell us the gist of the conversation?

**A.** Yeah. I'll just refresh my memory here a minute. This is a piece of an ongoing dialogue that he and I have had about Mr. Carson's diagnosis. And the dialogue concerns the role of his personality disorder, which is under the DSM-IV schema, the Axis II diagnosis, and it's relationship to any Axis I diagnosis that he has.

**Q.** What is the Axis II diagnosis?

*COMMENT:* This is a reasonable question because you want to know how well the expert understands the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (Text Revision) American Psychiatric Association, 2001. However, the attorney needs to be well versed in this text because for better or worse, it is the "bible" of medical-legal psychiatric diagnosis

**A.** The Axis II diagnosis is a Paranoid Personality Disorder with obsessive-compulsive and narcissistic features. But let me just say one more thing to explain myself. Put simply, the personality is the engine of the vehicle, and the Axis I diagnoses are the ornaments on the vehicle. But how a person experiences the events in their life is driven by their personality, and if it's a disordered personality, it's driven by their personality disorder. And that has a great deal to do with determining what, if any, Axis I diagnoses they develop. So that was the essence of this, and it's been an ongoing discussion. This is just one piece.

*COMMENT:* This is a seminal point because invariably when the Complaint includes emotional or psychological damages, they are exclusively Axis I diagnoses (Acute Psychiatric Syndromes such as those of mood, anxiety, psychosis, etc.) and not Axis II disorders, the personality disorders. These latter diagnoses are stable mental patterns that are established in early adolescence and are as proximate as is an event or circumstance that is alleged to have caused psychiatric damages in the plaintiff.

**Q.** Okay, continue.

**A.** I could read it if you —

**Q.** If you could tell me in your own words. I'm sure those things mean much more to you. What I'm interested in is what did he say to you and what did you say to him.

**A.** I don't remember the actual dialogue exchange.

**Q.** Of course not.

**A.** But the notes I took were personality disorder. When defenses don't work so well, they get Axis I syndrome.

**Q.** What's that? What was your understanding that was meant by that?

**A.** That means that — let's talk about Mr. Carson. Mr. Carson has a personality structure that I have diagnosed as a paranoid personality, which means amongst other things that he, in order to keep himself comfortable and try to be free of anxiety, does a number of psychological defensive maneuvers. He projects onto the outside world his own unacceptable impulses. It's not me who is enraged with you. It's you who is enraged with me. He denies those, and he externalizes some of those. And he feels out of his narcissism a great sense of self-righteousness and even at times entitlement, I believe.

**Q.** What would be an example of an entitlement he feels entitled to?

**A.** That he should have the judge rule the way he wants the judge to rule.

**Q.** It's not so unusual, is it? I wish it every time I go into court.

**A.** But you don't call the judge senile, I don't think, and that's the problem here. You may think it, but you don't say that to the judge. His sense of entitlement is so great and his hurt is so great when he's thwarted, when his view of reality is at odds with someone else's, because he thinks that his view of reality is the correct and the only one to be considered, when that happens, he begins to become more symptomatic. He may become depressed; he may become fearful; he may develop increasing anxiety like he did during the trial and need anti-anxiety medication; he may lose control over his anger and have outbursts like he did on that occasion and I gather on other occasions. So what's meant here by when the defenses don't work so well they get Axis I syndrome, all of it are reactions to the poor coping of the personality defenses. That's what I'm illustrating. A personality disorder

is a life-long condition that usually starts in late adolescence, early adulthood, sometimes earlier.

**Q.** And what did you — how did you determine that — speaking as a layman here, how do you know this was with him pretty much all his life?

**A.** I have to work backwards and forwards. Backwards, since he has all of the features of this personality disorder, I know from my knowledge of psychopathology that this personality disorder does not begin on the Tuesday after the accident, that it usually manifests in early adulthood or late adolescence. I know that from my expert knowledge.

Working forwards, I culled the records as best they were. And mostly what I saw in terms of early records were medical records going back to 1982 when he was a student at UCLA from Student Health. And what I see there is that it's inferentially supportive of a paranoid personality. He has a great deal of anxiety and a great deal of somatic worry. He has frequent visits with relatively minor physical complaints and clearly a lot of worry. Occasionally this sort of base line of worry spikes.

He has, for example recurrent concerns about warts, about growths on the foreskin of his penis. And later on after he's married he wants the entire family tested for worms even though the children who had them were treated for it. He's very concerned about contamination to his property, toxic and bacterial contamination.

**Q.** That was a real thing, wasn't it?

**A.** The bacterial contamination of his property? I don't know that it was. I know that he thinks it was. I don't have any independent data that it was.

**Q.** Sewage coming up on his property, wasn't it?

**A.** It was storm sewage. It's not raw excremental sewage. It's storm run-off, I think. That's my understanding.

**Q.** Okay.

**A.** So those are examples from the early data of his concern with issues of contamination and his high anxiety about his body. But the primary strength of my conclusion is based on a knowledge of personality disorders and how and when they manifest. It's also, I might say, supported by the testing done by Dr. Rosenberg, which is quite dramatic, and I'm sure you'll hear about that in his deposition. So where are we?

**Q.** I sort of took you aside there as you were telling me about your conversation with Dr. Rosenberg.

**A.** Personality disorder is lifelong. Then they try to act out the personality disorder using the legal system. When that doesn't work well, they get a lot of Axis I symptoms. This is sort of the sequence of explaining some of his present symptoms.

If my basic position is that there are people out there trying to hurt me, that's what I would call a paranoid position in most circumstances unless there's consensual reality confirming that. Doesn't mean people can't be hurt, but if you're fairly unique in feeling that there are people trying to hurt me at the city council level, supervisors, the voter level, then it raises a red flag about is this an accurate interpretation of reality, or is this a subjective projection onto reality, which I think it is.

He then uses the legal system, and paranoid litigants are a problem in the legal system. Because everybody's entitled to their day in court, but he uses the legal system to, quote/unquote, prove the existence of experiences, how he's been wronged, how he's been put against. And as that fails — for example, four out of five of his complaints were thrown out in summary judgment — he begins to become more symptomatic, more angry and more depressed and more anxious.

When defensive externalization — I'm quoting from this — of blame fails, Axis I disorders begin to surface. That's what I just said. Mr. Carson has a life-long need, in Dr. Rosenberg's view, to be Intelligent, to offer contributions, to be special. When this external validation of self esteem is not confirmed, he becomes depressed, and it increases his need to hunt for enemies.. Depression comes on. That's what I've called a — narcissistic and obsessional personality or alternatively a paranoid personality disorder with obsessional and narcissistic features, parentheses. I think that at the present time that's how he manifests himself. That's what I saw, and that's what Dr. Rosenberg saw on examination.

There's more fluidity to personality disorders. They're not rigid round pegs in round holes. I suspect that were I to see him, say, before 1995, what I would see would be a personality that would be more obsessional than paranoid and more narcissistic than it is now. The paranoid flavor would be in the background. But because of the extended period of stress and anxiety that he's been through, particularly around the litigations, there's been a shift, and I don't think he's in as good shape as he was at some earlier point in time, but I didn't see him then. This is my inferential guess.

*COMMENT:* This is an important dynamic point: loss of self esteem, due to failure in the litigation process, produces increased depression that, in turn, increases Axis I and Axis II symptomatology, in this case, paranoid concerns.

**Q.** When do you think he changed?

**A.** I think he began a change in'94 when the flooding started. Before that he seems to have been working well, he seems to not have public battles as a major part of his life activity. And I think it gets progressively more problematic for him to function without being totally preoccupied with his cases.

**Q.** Anything more?

**A.** His level of interpersonal functioning is higher than most paranoids. What that means is that — the point again is he's behaving — his personality disorder is such that paranoid individuals are so distrustful that they have really an impossible time getting close to anyone.

He has some of that, but he also has a 15-year marriage, which whatever it's quality, is 15 years endurance. He loves his children. He regards Dr. Perry as a very good friend, I think, and he has a few other friends. His relationships are on the surface better even now than one would expect from this paranoid diagnosis.

Finally the paranoia comes in spades in the more unstructured Rorschach test. To some extent — I don't want to, you know, usurp Dr. Rosenberg — not that I can. I don't want to speak from the position of his expertise. What I understood this to mean was that when you give him a pencil and paper test where you endorse things, for example "I have trouble sleeping, or I cry all the time," I'm just making these up as examples, he endorses most of the time, not always, answers that would reflect a reasonably well-developed person. He doesn't endorse "I am suspicious," again making this up, but whatever would signify in that test a high level of suspiciousness and distrust, he doesn't affirm those things. Why is this? I think it's probably because he's smart and wants to present himself in as positive a light as possible. I don't think this is malevolence on his part, but I think it's an effort to present himself in a way that looks as good as possible, and also he may believe that.

But if you do something that's quite different, and you give him an unstructured test setting where there are no right answers and there are no cues to the correct answer, the positive presentation answer, he begins to unravel, and he becomes more and more paranoid in that process, which Dr. Rosenberg will detail for you.

So that's the end of these notes.

**Q.** Next paper after that is dated Tuesday, 3–21, 8:30 p.m., ending 3–21 at 10:00 p.m. Is this a two-page document?

**A.** No, I think it's — let me see. Yes, it is.

**Q.** What is that?

**A.** The second page.

**Q.** No, what is the two-page document? What's that a record of?

**A.** This is an extensive discussion, a telephone discussion that I had with Dr. Rosenberg.

**Q.** What did he say to you, and what did you say to him to the best of your recollection? And I don't expect you to know the exact words.

**A.** May I ask you a question first? What was the date of the one I just read?

**Q.** Looks like 3–26.

**A.** Okay. This comes before that. So this is an earlier discussion about what I've just said. It's more condensed than the one I have just explained. This is five or six days before.

On the endorsement tests, that is the pen and — pencil and paper tests, he endorses evidence of depression, he endorses evidence of anxiety, of PTSD

**Q.** Now, why do you say he endorses depression and PTSD?

**A.** I can't answer that. This is a conversation I had with Dr. Rosenberg.

**Q.** Dr. Rosenberg told you that, and you don't know what he means?

*COMMENT:* Although there may be some desire on the part of the attorney to explore the extent of communication between the retained psychiatrist and the psychologist who has tested the plaintiff, with an experienced psychiatric witness, it is counter productive to ask him to interpret the psychologist conclusions.

**A.** I can imagine, but I don't know what he means. It's much better to get it accurately from the horse's mouth.

**Q.** Sure.

**A.** Some of these notes are so brief that I don't know what I was saying. Running around. I don't know what that is. Fear of bodily injury is an anxiety reaction. It doesn't qualify for PTSD. This speaks to the reason — this is actually his comment about confirming what I believe, which is that Mr. Carson does not have PTSD, and the reason is that he doesn't

meet the A, or event criteria, which is a threshold criteria. Without that you don't have the rest.

*COMMENT:* Fear or phobic concerns are symptoms. They do not necessarily imply a particular diagnosis. They may be consistent with the "avoidance" criteria for Post Traumatic Stress Disorder but by themselves are not diagnostic of that condition. For example they could represent symptoms of some other anxiety disorders such as agoraphobia or even panic disorder, or as in this example, paranoid personality disorder.

**Q.** And the threshold criteria is what that he doesn't meet? You can look at the book if you need to, or you can just tell me.

*COMMENT:* The "A" or "Event" Criterion for PTSD is:

The person has been exposed to a traumatic event in which both of the following were present:

1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2. the person's response involved intense fear, helplessness, or horror.

Note: In children, this may be expressed instead by disorganized or agitated behavior. The significance of the "event" criterion is that it is a threshold. Like pregnancy, you can't have a "touch" of PTSD, according to the DSM. You either have it or you don't and the "A" criterion is a significant filter.

**A.** I can tell you. The threshold criteria is fundamentally, with the exception of sexual abuse, which is a side bar issue, it's a life threatening event. PTSD comes out of a combat paradigm, manmade or natural disaster paradigm where death is either actual as you witness death or is reasonably feared or anticipated. The descriptor is a threat to bodily integrity. It's not sufficient, in my judgment, to believe that your bodily integrity is threatened. If it were, then a paranoid psychotic on the street who thinks that there's a green man across the street who wants to kill him could sue the city for not protecting him from this green man.

**Q.** If somebody walks up to you in a threatening manner, that is not necessarily an unreasonable conclusion to draw that you're going to be hurt or even killed. Would you agree with that?

**A.** No, I wouldn't. If someone walks up to you in a threatening manner as defined by objective consensual reality or your subjective sense?

**Q.** He's a man with a little black mask, and it's midnight, and you're in a dark alley, and says, "Hey, buddy, got a match?" And you walk away, and he chases you. Would that be–

**A.** That in itself probably wouldn't be enough to be PTSD. But if I was mugged at gun point, that is a life threatening encounter.

**Q.** So what you're saying is for PTSD there has to be a life threatening encounter in your opinion?

**A.** Yeah, has to be the experience of one or witnessing one. Let me put it even more specifically. If Mr. Carson had gone to the police station and had not been manhandled, but had witnessed another prisoner in custody being taken down, beaten, et cetera, he might have a basis then for believing — for the belief that there's a threat to his bodily integrity being externally substantiated. The problem is it's a purely subjective and paranoid fantasy in my judgment, and his fantasy is not a sufficient basis to make this diagnosis. It is a symptom of his disorder, but it's not a basis for a PTSD as his diagnosis.

**Q.** So if I have it correct here, when you're talking about threat to physical integrity in your opinion to qualify for a diagnosis in DSM-IV, this threat to physical integrity has to be a life threatening threat?

**A.** Witnessed or experienced. And with the exception of sexual abuse, yes.

**Q.** Have you ever heard any discussion in the psychological or psychiatric community that perhaps a threat to something less physical, for example, some kind of threat to one's mental integrity or intellectual integrity, have you ever heard discussions that might qualify for a discussion of PTSD, or should qualify?

**A.** Yes, I've heard some discussion of that.

**Q.** Where have you heard that?

**A.** I can't remember, but it's — you know, are — in trauma studies there are various kinds of trauma, and usually the psychological trauma events like being a prisoner of war are also including physical trauma, but certainly deprivation. If you put someone in an isolation cell for weeks, most people will begin to have psychotic symptoms under those circumstances.

So I'm aware that a threat to one's mental integrity can be a stress, but that's not the same thing as a subjective belief about a situation where any reasonable man or woman observing the circumstances would come to a very different conclusion about what was going on.

**Q.** You're talking about the fact that he saw one of the officers look around and then duck back. Are you saying that a reasonable person wouldn't think something was up? I don't know, maybe I'm putting words in your mouth. That's what you're talking about, isn't it?

**A.** I'm talking about — no, that's not what I'm talking about. I'm talking about his belief that he was going to be taken down by the police. What came to mind was the L.A.P.D. beating of Rodney King. That Officer Gordon I think was of short stature and might well have a Napoleonic complex and want to beat him because he is a large man, Mr. Carson. These are projections of his own fantasies. These are not accurate assessments of what's going on in the circumstance unless they were —

**Q.** Tell that to Rodney King.

**A.** No, no, I'm not saying Rodney King wasn't beaten. I'm saying that Mr. Carson wasn't threatened with a beating, that the association is in his mind, not in the objective reality. That's what I'm saying.

**Q.** Okay. Continue on there with your — you were talking about your conversation with Dr. Rosenberg.

**A.** He says he provoked his vendetta — I'm not sure. These are two different lines. He provoked. His vendetta. I don't remember what that was about. On paper and pencil is one line. Next line is on Rorschach he looks aggressive, he looks paranoid. This is essentially what I said before. Anxiety, depression, obsessed, high anxiety, distractability. High anxiety is ego-syntonic. What that means is I'm not sure.

You know, these are just notes that I'm jotting in fragments as we're talking. Ego-syntonic means a symptom which doesn't bother you. So what he appears to be saying on the surface is that his high anxiety isn't bothering him. I don't think that's the case. I think his anxiety's bothering him a great deal. I don't know why I wrote that, whether it was a fragment of another sentence.

Contamination fantasies. I discussed this with you. But his contamination fantasies may come up in his Rorschach testing data. I'm not sure. Or the Thematic Apperception Test, which is the other projective test.

Themes of contamination and invasion. The flooding was experienced by him as a contamination and an intrusion. In paranoid individuals boundaries are extremely important.

There's a brittleness around anything that could be experienced or imagined to be an intrusion, and he exhibits that. Something happened, and then it gets focused. This is the way a paranoid individual integrates their perception of reality. An event happens, and then it goes through the filter of distrust, looking for hidden meanings, looking for conspiracies and not obviously apparent threats in the environment.

Obsessional preoccupations leading to paranoid decompensation. There is a theory in psychopathology that obsessional behavior, and that is, you know, people have to line up all their pencils and put rounds pegs in round holes, are very concerned with order and control, under sufficient stress can become frank paranoia, and that there's a spectrum, and that people can fluctuate between the paranoid end and the obsessional end depending on whether they are healthier or more ill at a moment in time or at a period in their lives. And so that's what he was referring to.

Paranoid anxiety is not the same as PTSD, which is what I said. He commented that he's very smart. He tested narcissistic on the MCMI, which is a self-report pencil and paper endorsement test.

On Axis I he had a cluster of responses, but this is not yet integrated. So I'm giving you the unsynthesized unformulated conversation with Dr. Rosenberg. Generalized anxiety disorder, PTSD, and adjustment disorder with depressed mood. That is the descending importance on the test or descending high endorsement level. Major depression shows up as a feature.

**Q.** Do you know what he meant by that?

**A.** Yeah. There's a hierarchy, the most being disorder, the next being traits, the third being features. And in this particular — this is really talking about the MCMI test. Those are general characteristics in diagnostic nosology. It's in the dictionary) But in this test in particular I believe — I don't know this test other than what he told me — certain levels of scores get you from one category into the next, into the next. So if you have the highest score, you're within the disorder; and below some, you're in traits; and below that, in the feature. He says that major depression shows up as a feature. Dysthymia shows up as a feature or frank disorder.

Dysthymia is a lesser, more chronic level of depression. Narcissistic personality shows up as traits.

And then I have a list of disorders here. I don't know why they're there. Dysthymic Disorder, Somatoform Disorder, Major Depression, Delusional

Disorder, Narcissistic Personality Disorder. On the Rorschach there's no evidence of PTSD So he poses the question.

*COMMENT:* This whole line of questioning is confusing and of little value. The witness is being asked about another expert's testing conclusions. Counsel could have used his time better deposing the psychiatric expert about his conclusions and his evidence rather than focusing so much on the psychological testing which is better covered in the deposition of the psychologist expert who did the testing.

**Q.** Did you come to any conclusion, or did Dr. Rosenberg express a conclusion?

**A.** I think the conclusion after his going over the testing carefully was that Paranoid Personality Disorder describes him accurately. And I think that's the other thing that you need to realize in this whole area of diagnosis is that there is a clustering. These are again not discrete categories, except PTSD, which is for legal/medical purposes like pregnancy, you either have it or you don't. But the general categories of personality disorder, is it paranoid, is it narcissism, is it obsession, is it schizoid, you see overlaps. So you make sort of a relative quantitative judgment call about how much is it in this camp versus in that camp. And that's why you may say this is what it is and then have descriptors with features of the other.

**A.**

He says high level of anxiety, some tendency of impulsive acting out. That means losing control. This is a man for whom control is obviously very important. That is, having things structured tightly, being able to anticipate problems in the future and prevent them. These are all the —

**Q.** Living an ordered life?

**A.** Living an ordered life. These are all high needs for this individual, and they go with obsessional character structure. It's not pathologizing. It's very adaptive in our society to be obsessional. It makes you a good accountant.

So in that regard — but part of that is the purpose of all of this ordering is to prevent bad things from happening, unexpected things from happening, and to maintain control. What Mr. Carson experiences is under certain circumstances a loss of control, and it causes him great distress because it's against his sort of core view of himself, someone who is in control.

Emotionally labile, that means mood can swing from extreme sadness to elation back and forth or even from a fairly even state to depression and back again fairly rapidly.

And then no symbiotic things going. I mean, I don't know what that means, but — I don't know what that refers to. Symbiotic means quality of relationships that are characterized by enmeshment, where you end and you begin is unclear. And there are people who have this in spades in their relationships.

**Q.** Let me ask you something about paranoia, and I realize it's not a very — well, let just ask you. If John Dillinger, the bank robber, came to you and complained that he thought people were after him, how would you distinguish whether he was paranoid?

**A.** Just because I'm paranoid doesn't mean people aren't after me.

**Q.** Right.

**A.** I think what's most distinguishing in Mr. Carson's evaluation is his psychological testing in this area. I can listen to his narration of events at the arrest and understand what he's telling me and understand that his perception is that he was objectively threatened in various ways. Someone else's view of that event may be nobody threatened him, what are you talking about? I wasn't there, so I don't have my own experience to measure those reports against.

But there is, in addition, as in my job, a body of data to look at about how did Mr. Carson respond in other situations. Was it again a toss of the coin? Is he being — is there a conspiracy against him or not, or was it an idiosyncratic or more idiosyncratic view, interpretive view of the events?

But then you take it to psychological testing and look at the projective tests. It's really quite dramatic. Because in that setting where there's no agenda other than to say whatever you perceive — there's a lot of data, there's tens of thousands of cases to compare those to, but there's no agenda in the test — what you see according to Dr. Rosenberg is frankly paranoid perceptions.

And the style of taking the tests, which is one of the things that's also evaluated, that's consistent with that. So if John Dillinger tested that way, I'd say he's probably paranoid. If he didn't, I would say he's just realistically assessing the threats that he faces.

*COMMENT*: Counsel offers an implied hypothetical situation to attempt to discredit the diagnosis of Paranoid Personality Disorder. It doesn't succeed.

**Q.** Well, is there somebody like John Dillinger — let's say the police have been after him for months or even years. Would that affect the way he took a test? In other words, if he took a test a year ago, and then the police — then he was on the run for a whole year and then took another test, these kind of tests you're talking about, would you expect to see any difference?

**A.** Well, this is really an excursion, but I'll go with you. Paranoids don't make great criminals. Mr. Carson has a very good conscience, an overactive conscience one might argue. John Dillinger presumably — I didn't know John Dillinger or haven't even studied John Dillinger, but let's assume that he's some prototypical criminal. He would be sociopathic primarily, meaning that his attitude would be I'm entitled to whatever I want however I get it, and it's irrelevant what price anyone else has to pay for me to be gratified. That's a sociopathic instance. That would probably be his main profile rather than paranoid, even though he might have some concerns that people are out to get him, which would be a realistic assessment of his environment because the police are out to get him.

**Q.** So how does that show up on the test, if it would at all?

**A.** I don't know the answer to that. You'll have to ask Dr. Rosenberg.

**Q.** Okay. So what you're saying is that the — in defining somebody, whether somebody like Mr. Carson has some kind of a paranoid personality — is that —

**A.** Yes, Paranoid Personality Disorder.

**Q.** It would be tough to assess it because maybe he's right. Maybe they are all after him. You might not have enough information gathered to conclude something along those lines.

**A.** Well, not exactly. You're generalizing. What I said as a particular instance, if all I had was one instance to look at in an individual and there were, say, let's say two diametrically opposed versions of what happened, I don't have a crystal ball. There's no way that I can say it was X or it was Y.

**Q.** Or it could be Z, too.

**A.** Could be Z.

perceptions of and allegations of discrimination and conspiracy.

*COMMENT:* Implied conspiratorial allegations can be suggestive of paranoia although true conspiracies obviously exist. However, overt allegations of conspiracy raise the threshold of suspicion further. The burden falls to the plaintiff to convincingly demonstrate why this is irrefutably an example of conspiracy rather than a characterization that the plaintiff has inferred whereas other reasonable people could interpret the situation far less malevolently.

**Q.** What was the — what were the — what was the discrimination and conspiracy?

*COMMENT:* This is a reasonable question as the attorney seeks to evaluate the judgment of the psychiatrist that these allegations of conspiracy were more symptomatic of paranoia than objectively a part of consensual reality. For it is consensual reality that is the arbiter here; not the myriad of subjective realities that plaintiffs, clinicians and attorneys bring to the litigation.

**A.** The conspiracy, he felt that he was being treated differently than other residents of Santa Barbara in the services that he got from the city. Let me just, if I may, look at my notes.

**Q.** Sure.

**A.** Because this is from memory. Yes, it starts off with just a general state of the dispute. The attorney who is deposing him, says, "There have been occasions when you cleared debris from the gutters from in front of your home, haven't there?" And Mr. Carson answers, "Almost every day there is some litter on my property or in front of my property." "And you believe that's the City's responsibility?" is the question. And the answer is, "Yes."

**Q.** "Because the litter you believe is coming from residents from a city owned building?"

**A.** "That's correct."

**Q.** A couple of pages later he's asked, "Do believe that the City of Santa Barbara is providing you with less services as compared to other citizens in the city?"

**A.** "Yes."

**Q.** "What leads you to believe that the Santa Barbara is providing you, with less services than other homeowners or residents?" I think that's meant to be residents of the city. And then there's a quibble over what residents means. It's asked again.

"No, it is what leads you to believe that you are receiving less services."

**A.** "Santa Barbara has been working to replace the streets, sidewalks, curbs and gutters, and it's my understanding that that plan also includes replacing the storm drain."

**Q.** "What's your quarrel with the services or construction occurring on Manzanita Avenue?"

**A.** He says, and what you're seeing here now is a digression into another issue "I believe that that's a different level of service than I am getting."

**Q.** "And you believe that the City has decided to work on Manzanita Avenue as opposed to Franklin Street, Mr. Carson's street, "with considerations of you personally?" That's the important thing, of you personally.

**A.** "Yes."

[The attorney shifts to another topic].

**Q.** On page 12 of your report it's my understanding you talk about an Axis I diagnosis, and you say Anxiety Disorder N.O.S.

**A.** Yes.

**Q.** And Depressive Disorder N.O.S.

**A.** Yes.

**Q.** You ruled out Posttraumatic Stress Disorder, or you say it does not meet that criteria anyway.

**A.** Right, yes.

**Q.** Is that primarily because of the physical integrity thing?

**A.** It's because of the threshold

If it doesn't meet the threshold, then the rest of the B, C, D, E, and F criteria are really irrelevant so far as making that diagnosis.

**Q.** Let me ask you this. Did you consider the B, C, and so forth diagnoses?

**A.** I did.

**Q.** And did he meet any of those?

**A.** I'll have to go through it now and tell you if you'd like me to.

**Q.** Okay. Now you're referring to the DSM-IV manual?

**A.** Yes.

**Q.** What section or —

**A.** Page 427, 8 and 9, which is diagnostic criteria for Posttraumatic Stress Disorder. The B criteria I notice is the reexperiencing criteria, and you have to meet it in one or more of the following ways. And he meets one, which is recurrent and distressing recollections of the event.

Number two, which is recurrent dreams of the event, I would take issue with because I believe that the dreams he has, which are disturbing dreams, they're not PTSD dreams.

*COMMENT:* Typical PTSD dreams are initially an almost literal replaying of the traumatic event with almost none of the symbolization and disguise that usually characterize dreams. Later on in the illness, after the intervention of psychotherapy, dreams become more symbolic although the general themes of the traumatic event may continue to be reiterated.

**A.** The criteria of acting or feeling as if the traumatic event were recurring, a sense of reliving the experience, doesn't characterize his present state.

The criteria of intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event does not characterize him either. He's not in a cold sweat when he walks by the police station as far as I know. I asked him about that, but I don't think it fills this criteria. He's avoided community meetings since the arrest, but that is probably accounted for better by anxiety rather than an avoidance of returning to a traumatic setting.

The criteria of physiologic reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event is also not met. I think he has a lot of anxiety, but I don't think it's specifically related to reexposure to the trauma as somebody who was in a plane crash and gets to the airport and breaks out in a sweat and would have dilated pupils.

So he has one of the B criteria which meets the definition for the diagnosis under the B criteria.

The C criteria, the avoidance criteria, you have to have three or more. Efforts to avoid thoughts, feelings, or conversations associated with the trauma. Not only does he not avoid it, he's obsessed by it. He can't talk about much of anything without it coming back to it.

Efforts to avoid activities, places, or people that arouse recollections of the trauma. I'm not aware of that being met.

Inability to recall an important aspect of the trauma. This is fuzzy. The only fact that he told me that might fit that is he said he learned that one of the police officers came over

to the police car when he was being loaded into the police car and said, "You're under arrest," and he has no recollection of that. What this usually applies to, though, is what's known as a dissociative break that happens during an acute trauma like a serious car accident, where a person is rear-ended, and they looked in their mirror, they saw a car coming up what seemed rapidly behind them, and the next thing they know they're lying on a stretcher on the ground. And all the events in between with that loss of consciousness are blacked out. He doesn't seem to have that kind of problem except this gray area of the recollection of the police officer.

**Q.** What about the discrepancy between the testimony of the officer and him as to whether he was placed in a holding cell? You recollect that?

**A.** Yes, What are you asking me about that?

**Q.** Is that a blank spot that might fulfill this criteria?

**A.** That's a good question. I mean, assuming that he was not put in a holding cell?

**Q.** Right. Whether he was or not, that's a yes or no thing.

**A.** He recalls something that the other observer says didn't happen rather than not recalling something which clearly did happen. So that doesn't fit this.

**Q.** On the other hand, then, he wouldn't recall being taken straight into the interview room. If he says I went here, and it turns out he really went there, he wouldn't recall going there.

**A.** I'm not sure what you're asking me.

**Q.** What I'm saying is if I say the police brought me to San Diego, and it turns out the police brought me to Newport Beach, I would have forgotten that they brought me to Newport Beach. You see the logic I'm getting at there? So in other words, I would have remembered something in addition, but I also would have forgotten.

**A.** Could be any number of explanations. I don't think it fits there. I think there's another explanation as to why he and Officer Smith have differing testimony.

**Q.** You have any suggestions why that would be?

**A.** It's a hypothesis again. This is a good example of two very different reports of an event, and I have no way without having been there or some record, which I haven't seen.

**Q.** We don't know for sure?

**A.** Whether he was in a cell or in the — but I would say this. I think that he was very distressed about this arrest at the time. Call it anxiety. Call it upset. He's very distressed. I think he was humiliated. I think he was shocked, actually, that he was arrested by the police. I think he was shocked by it.

As best I can reconstruct, and there may be holes in this reconstruction, he's brought to the police station, and he says he's put in this very small holding cell that he describes in detail, and the officer says he was never put in a holding cell. One possible explanation is in this altered state of consciousness that he was in; very distressed, that he sat somewhere and saw a holding cell, maybe looked into it from where he was sitting. And feeling very threatened, clearly he thought he was going to be taken down, thought that's where I'm going next. And in the way the mind can play tricks, that became a memory rather than a fantasy. That's a possible explanation, but I don't really know what happened.

**Q.** Going back to criteria C, move on.

**A.** Criteria C, avoidance. Markedly diminished interest or participation in significant activities. I think this applies to him. Number five, feeling of detachment or estrangement from others. I don't think that that applies to him. That's a very particular state of withdrawal from any contact with people. My impression is there are certain people whom he trusts who he has a great deal of contact with. He's had, you know, 400, 300, 400 meetings with Dr. Perry since this all began. He's not in isolation hiding as sometimes people do who have survived a traumatic event.

Restricted range of affect. I think he had this prior to being put on antidepressant medication. I think what he had in that context was constricted affect, which is diagnostic of depression. In that clustering most people with PTSD also develop depression eventually and there's an overlap. So I think that his restricted range of affect prior to the medication would literally fit this, although I believe it has to do with his depression.

Sense of foreshortened future. I don't think he has that at all, not the typical PTSD type of foreshortened future, which is this: PTSD ruptures our bubble of invincibility which we all have or else you couldn't get on the freeway when you leave here and drive here because it's scary to be in a metal container at 60 miles an hour. When something happens that is a life-threatening event, suddenly you feel enormously

vulnerable to death and that death is just anywhere around, there is no future.

It's a sort of theoretical construct rather than something you bank on, count on, plan for, and I've seen this in PTSD patients. He doesn't exhibit that. In terms of the future, if I don't win this case, I'm taking it to the Supreme Court, this is his mission. He's got very much a sense of what he's going to do tomorrow and tomorrow and tomorrow, at least in regard to this case.

So three or more. I think he has possibly four and possibly six. He has restrictive range of affect. I don't think he meets the C criteria. Again, I'm going through this now because I did not go through this exercise, having had volumes to go through, and I decided clearly that this wasn't the right diagnosis.

The D criteria: Persistent symptoms of increased arousal. Difficulty falling or staying asleep. This he has. And you need to have two or more of the following: irritability or outbursts of anger. This he has. Difficulty concentrating. This he has. Hypervigilance he has in spades. Exaggerated startle response. He says he does, but I actually tried to test him, and he didn't respond at all. So he has the D criteria. And the rest are just — you know, duration more than a month. His symptoms are more than a month's duration. His disturbance suggests significant stress or impairment in social, occupational, or other important areas of functioning. This does.

One last thing. PTSD falls under the rubric of Axis I, which is an Anxiety Disorder. I have no doubt that he has anxiety, and I gave him an Anxiety

Disorder diagnosis. So the symptoms that relate to anxiety I agree he has.

**Q.** Does it really matter whether it's called PTSD? He's got problems; right?

**A.** It matters for at least a couple of reasons. One is it matters to me professionally to be accurate. The PTSD diagnosis is not a wastebasket category, it's not big, bad stress. Otherwise call it big, bad stress and not go to all this trouble. It also matters in my understanding legally, because the causation is implied with this diagnosis, and that's half the task, as I understand it. And without this diagnosis the causation has to proven, presumably, before a jury.

**Q.** Okay. You mentioned — also on page 12 of your report you mentioned Depressive Disorder. Is there something called major depressive?

**A.** Major depression?

**A.** Yeah. Dr. Perry gave him that diagnosis.

**Q.** And you don't think he has that, or at least you didn't come to that conclusion, or did you? What's your opinion about that?

**A.** May I back up for just a minute?

**Q.** Sure.

**A.** One area diagnostically that I was not sure of, and I included as an appendix to my report a description of generalized anxiety disorder. This may be more hair-splitting to some degree than whether it's PTSD or not. I put Anxiety Disorder N.O.S., but it may be that he has a generalized anxiety disorder, and they're similar. The N.O.S. diagnosis is more one of exclusion when it doesn't quite meet all the criteria of the other explicit anxiety disorders. As far as his Depressive Disorder N.O.S. versus major depression or the variations on that, there are many variations. Let me tell you why.

Again, looking at the DSM-IV page 327 criteria for major depression, five or more of the following symptoms must have been present during the same two-week period and represent a change from previous functioning. At least one of the symptoms is either depressed mood or loss of interest or pleasure. Depressed mood most of every day, nearly every day.

Before I go into that, let me say something else. I am diagnosing him as I see him a couple of weeks ago. He's had psychotherapy since March of'98 regularly, and he's had medication since October of 1998. So I presume from that and the report, what he told me, what I know about how people respond to treatment that he's in better shape now than he was at some point in the past. I'm certain of that. I know that he had suicidal and homicidal fantasies at least last summer, I think. So the fact that he doesn't meet right now a major depressive disorder in my judgment may not mean that he didn't meet it at some other time in the past. So let me just say that parenthetically.

**Q.** Would you be able to tell — would you personally be able to tell whether he did meet it in the past? In other words, is there some way you could find out? Or you're just saying I can't say whether he did or not in the past?

**A.** You know, the best evidence for that, he's not an unexamined patient. He's got — both treating doctors examined him and despite an initial rule-out diagnosis have diagnosed him as having Depression N.O.S. and Anxiety Disorder N.O.S.

That's how they repeatedly submitted their request for authorization for treatment to the managed care company. So I agree with them those are his diagnoses. And they would have an ongoing database with which to say, no, this is really a major depression.

**Q.** And Dr. Schultz, he said he didn't really rule it out or didn't really come to any conclusion, didn't he? Do you recollect what he said?

**A.** In his deposition?

**Q.** Yes.

**A.** I just got it yesterday and read it really quickly, but I had looked at his records. He has it as a rule-out diagnosis at his first evaluation but then drops it and only submits — let me put it this way. If he were — if he believed that he had major depression, he'd have a much stronger case in requesting visits from the managed care company. To say he's got major depression rather than saying Depressive Disorder N.O.S., it's more serious, so — also, as I recall his testing, particularly the projective testing doesn't score high for depression. Now, that may well be because he's in better shape now than he was or may not be. So I could go through some more.

**Q.** You started to explain to me about major depression. What is Major Depressive Disorder?

**A.** Major depressive episode is the sort of keystone, and then there are variations on that recurrent single episode. But they all refer back to this depressed mood most of the day and nearly every day. I don't think he has that markedly diminished interest or pleasure in all or almost all activities most of the day. He has a diminished interest or pleasure in activities. I'm not sure if it's all. For example, he does household projects; it's something he's interested in and has pleasure doing.

Significant weight loss when not dieting or weight gain. I'm not positive, but I think I asked him about weight changes, and he didn't have a significant weight change, but I'm not positive about that.

**Q.** My recollection, I think his weight may have gone up and down from time to time, but that's just my recollection.

**A.** Okay. Insomnia or hypersomnia, meaning sleeping all the time, nearly every day. He has insomnia frequently. I don't know if it's every day. Fatigue or loss of energy nearly every day. He has some fatigue, but he also has — he's been taking

very high doses of Paxil. It's now been tapered down. But, in fact, he was given 20, then 40, then 60 milligrams, and he upped it to 80 milligrams. Paxil can be very sedating, so it's difficult to separate what is drug effect from what is underlying disorder. And also because the drug effect helps with these symptoms in other — he is also taking Klonopin and Atavan. So I would just pass on that one.

Feelings of worthlessness or excessive or inappropriate guilt, which may be delusional. He doesn't have this. What this is, in depression — doesn't mean that he doesn't feel guilt at times or question his value, but in depression of this kind the person feels I'm no good, I'm terrible, everyone knows I'm worthless, that kind of thing. Rumination about his lack of value. He doesn't have that.

Diminished ability to think or concentrate or indecisiveness nearly every day. He has that a lot. I don't know if it's nearly every day. I saw him in one little snapshot.

Recurrent thoughts of death, not just fear dying, recurrent suicidal ideation without a specific plan, or a suicidal attempt or a specific plan for committing suicide. He did, and I think it was last summer,'99, have a period of feeling suicidal. I think it may have been after he initially lost the motion for continuance of trial. He had homicidal fantasies as well, and he had suicide/homicide fantasies.

**Q.** On page 17 you say his pre-existing personality disorder was at least as much a, quote, proximate cause, unquote, of his emotional difficulties following the May of 1997 incident as was any impact from the arrest — excuse me, the incident itself.

**A.** Yes.

**Q.** I'm not quite sure what it is you're getting at there. Are you saying these things both contributed to his condition after the arrest, or what is it? Maybe you could explain what you mean by that.

**A.** One of the questions in this case that I'm asked to have an opinion about is does he have a psychiatric disorder or psychiatric symptoms, and if he does, to what extent, if any, were they caused by or exacerbated by the issue in dispute in this case, I guess the wrongful arrest charge claim. That gets to the whole notion of what causes what. There is a difference in the point of view, the perspectives of the law and the behavioral sciences in this regard. And so speaking as a clinician, I come down on one side of this, more on one side

of it than another, which is in general it's very difficult and possibly impossible in a psychiatric damages case to say what caused what, in contrast to the car hit my leg and broke my bone.

The reason for this is that we all have personalities which influence how we manage the events that we experience, and if we have a personality disorder, that may heavily color how we experience the events that happened. That's why I would argue that this man's alleged complex reaction to the arrest, the psychological reaction, I'm not talking about freedom of speech issues, is different from another person who might have taken it in their stride, might not have liked it, but certainly wouldn't have claimed PTSD as a result. Apart from someone who is a habitually being arrested. This man didn't just say, hey, I don't like this, I'm angry, it was wrong, so on and so forth. He says I have been very badly damaged by this psychologically, and these are my diagnoses.

So I'm saying to the extent that he has had a lot of psychological symptoms in this period, and I believe he has, they're as much a product of the personality disorder that he brought to the moment of the arrest as they are the events that transpired. I also think that a great deal of his anxiety, I think he said to me and in testimony, has to do with litigation and the stresses of the litigation. But that's a separate issue.

So that's what I meant by my proximate cause statement, that it was —

**Q.** Let me ask you this. But for his arrest on May of 1997, would he have the mental and emotional problems that he has today?

**A.** I think he had them in his prior lawsuit with the City of —

**Q.** But that lawsuit's over; right?

**A.** Yeah.

**Q.** Shouldn't it have cleared up if that was the cause of it or —

**A.** No. I didn't say it was the cause. He had them in that period. If you say but for the arrest he wouldn't have these, but for the car hitting the leg, it wouldn't be broken. But what was he ten seconds before he was arrested? He was a man who, I am saying, has a Paranoid Personality Disorder who had been under a lot of stress from the prior lawsuit, from various other disputes with the city and from a particular frustration about their not handling his complaint of the trash the way he felt they should handle it. So all that is there before the arrest.

**Q.** So if he hadn't been arrested, would he be where he is today?

**A.** I have no way of predicting that. But he had symptoms before that, and to the extent that they were — to the extent that I am correct that he has a personality disorder, he would have had those — he would have had symptoms without the arrest. He might well have glommed them onto another event in his life. That's what I was talking to you about from Dr. Rosenberg's description of how a personality disorder drives the Axis I diagnosis.

**Q.** Would you say then that the arrest was not a cause of —

**A.** No.

**Q.** — what his problems are today?

**A.** No. Nor would I apportion it.

**Q.** Would you say it was a causation?

**A.** I would say that a number of things happened to a man who had pre-existing psychopathology. And the arrest was an event that was disturbing to him. And his litigation over the arrest has been series of events that have been extremely disturbing to him. That would be, I think, the fairest description of what I think about this.

**Q.** If you're asked in court to say whether the May of 1997 arrest was a cause of his emotional problems he's experiencing today, would you have an opinion?

*COMMENT:* This is where the proximate causation of personality disorders (in contrast to Axis I disorders such as PTSD) is discussed. To the extent that the existence of prior personality disorders predates his symptoms, they cannot or cannot wholly be attributed in a "but for" manner to the incident under dispute, in this case the Plaintiff's arrest.

**A.** It would be just what I said just now. That it was one event in the context of a man with pre-existing psychopathology and with a big reaction to the litigation aftermath of the event.

**Q.** Well, he experienced a lot of symptoms before he filed the lawsuit; correct?

**A.** Yes.

**Q.** He started having trouble concentrating, had diarrhea, for example?

**A.** I don't remember. I'll accept that that's true. I don't remember the date that he filed his complaint.

**Q.** I think you have to file a claim with the City. I think that was in October. I think they rejected it in February, following February, so probably almost a year later, I suppose.

**A.** So he filed a complaint in October, which is six months or so after —

**Q.** Six months after the suit.

**A.** So he had symptoms.

**Q.** Would that indicate to you that probably the arrest was a cause of those symptoms?

**A.** To the exclusion of anything else going on in his life at the time?

**Q.** No, no, the inclusion of anything else, would the—

**A.** Yeah, I've said the arrest is an event that happened to him that upset him, and that–

**Q.** And would you say it resulted in some of these symptoms like forgetfulness and diarrhea, for example?

**A.** I wouldn't necessarily say that. I think his anxiety results in his diarrhea. But did it result in his having a diagnosis of Anxiety Disorder N.O.S.?

**Q.** Or Depression N.O.S?

**A.** Yeah, I think he became depressed after the arrest. I think it was a big narcissistic blow, yeah.

**A.** [The deposition ends shortly after].

*COMMENT:* Plaintiff's counsel gets me to agree that the arrest depressed him because it was "a big narcissistic blow" to his self esteem. However he has not succeeded in gathering any information that will be decisive in a cross-examination. Plaintiff's counsel failure to educate himself prior to deposition has resulting in a low yield from this deposition.

## § 716.06 Analysis of Depositions

It was evident from counsel's comments that he was not sufficiently prepared to depose a psychological expert or a psychiatric expert regarding the assessment of PTSD in his case. The attorney had no idea about what the standard psychological tests were, how they were administered and interpreted, even though his own expert used many of the same tests. He failed to take advantage of his own expert psychologist to prepare for deposing the opposing expert in the case.

The attorney was not familiar with the criteria for post-traumatic stress disorder as listed and described in the DSM-IV. He did not understand the distinction between an Axis I acute disorder like post-traumatic stress disorder, anxiety or depression and an Axis

II Personality Disorder like paranoid personality disorder. His lack of understanding of this distinction—especially that personality disorders pre-exist a traumatic event that are experienced in middle age, did not allow him to effectively depose and challenge the expert's opinions.

In the first deposition of the psychological expert, the attorney spent an inordinate amount of time inquiring about the expert's prior experience. Although this can be a useful line of inquiry in some depositions, it was not yielding this attorney much and he should have moved on more quickly to more promising areas. The attorney did not make effective use of hypothetical questions. Although the use of hypotheticals is a common practice during depositions, the potential yield must be carefully weighed against the risk of skilled evasion by an experienced expert witness. Hypothetical questions should be asked very sparingly and very strategically, which was not done in this case. In deposing the psychiatrist, the attorney spent an inordinate amount of time asking the psychiatrist about the psychological test data that he could not interpret. He would have been better off saving those questions for deposing the psychologist.

This case went to trial and the defendant lost. While the deposing attorney lost the case for a variety of reasons, his poor preparation for the depositions contributed to his defeat. There are several important lessons attorneys can learn from this case. First, and most important is that counsel should be well prepared prior to deposing a mental health expert. Counsel should be familiar with the all of the diagnostic criteria for post-traumatic stress disorder and every other psychiatric disorder that is at issue in the case. This familiarity includes the ability to establish whether the alleged event met the "A" or Event Criteria in DSM-IV. If the event criteria was not met, by definition, the plaintiff did not suffer from post-traumatic stress disorder. Attorneys deposing experts on PTSD should be prepared to carefully inquire about this event criterion in order to establish there is a factual basis for a claim of the disorder.

Counsel must be familiar with the distinction between pre-existing personality disorders on Axis II of the DSM-IV and acute symptom disorders listed on Axis I. Every expert—whether retained by plalintiff or defense–should consider the possibility that the psychological damages alleged by the plaintiff may have been a result of a pre-existing condition and not due to the alleged injury. Counsel must be thoroughly prepared to explore this issue; if an

expert has convincing evidence for a pre-existing condition, the plaintiff's damages may not be wholly or even partially attributable to the allegedly causative stress event and the proximate causation issue will be heatedly disputed by the defense. Another area an attorney should be familiar with are the methods used by psychiatrists and psychologists to assess the credibility, honesty and openness of the plaintiff as well as to evaluate the possibility of malingering or the plaintiff's motivation for secondary gain.

Louis Pasteur said "Fortune favors the prepared mind." When it comes to depositions, fortune favors the prepared attorney.

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