ORIGINAL
#629

STATE OF OHIO)
)
COUNTY OF GEAUGA)

COURT OF COMMON PLEAS

RENO REDA, et al.,)
)
Plaintiffs,)
)
vs.) Case No. 90-M-000704
)
FRANK DuGUID, et al.,) Judge Inderlied
)
Defendants.)

- - -

Deposition of CHRISTOPHER LAYNE, Ph.D., a Witness herein, called by the Plaintiffs as if upon Examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Casey Gotthart, a Registered Professional Reporter and Notary Public in and for the State of Ohio, at the offices of Layne Psychological Services, 3450 Nest Central Avenue, Toledo, Ohio, on Friday, July 12, 1991, at 12:05 p.m.

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I N D E X

ATTORNEY	EXAMINATION
Mr. DeRosa	4

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E X H I B I T S

None

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CHRISTOPHER LAYNE, Ph.D.,

a Witness herein, called by the Plaintiffs as if upon Examination, was by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION

BY MR. DeROSa:

Q. All right. Doctor, as you know, I've introduced myself. My name is Joe DeRosa. I represent Reno Reda and Margaret Reda in a lawsuit that's been filed against Frank DuGuid. I understand you have been deposed before.

A. Yes.

Q. So you know the groundrules. You have to answer verbally, no hand gestures, talk loudly and clearly, correct?

A. Yes.

Q. You know that if you don't understand a question, you're to ask me to repeat or rephrase the question so that you understand what the question is, correct?

A. I understand.

MR. DeROSA: This deposition is being taken pursuant to agreement of the parties; is that correct?

MR. MORAN: Correct, notice and defects are waived.

Q. Doctor, you conducted an evaluation of the plaintiff, Reno Reda; is that correct?

A. That's correct.

Q. And as part of that evaluation, you generated a file, and you have obtained certain materials; is that correct?

A. Correct.

Q. Do you have your file with you here today?

A. Yes, I do,

Q. Is that your entire file that you generated on Mr. Reno Reda?

A. Yes.

Q. Are there any materials that are here in your office that are not contained in that file pertaining to Mr. Reda and your evaluation of him?

A. No.

Q. May I take a look at your entire file, please?

A. Yes.

MR. DeROSA: Let the record reflect that Dr. Layne has handed to me what he has identified as his entire file of Mr. Reno

Reda.

Q. Doctor, as I'm going through the file, I have your confidential psychological evaluation of Mr. Reno Reda, and that is the same report that you provided to Mr. Moran?

A. Yes.

Q. And I take it that is the same report that has been provided to me as well?

MR. MORAN: That is the report that I received from Dr. Layne that I also sent a copy of to you.

Q. The file also contains what is entitled Millon Clinical Multiaxle Inventory II?

A. Yes.

Q. And is that the test that you gave to Mr. Reda?

A. Yes.

MR. MORAN: That is the test that I copied. When Mr. Reda took the test that day, that was copied and given to him when he was finished with the test, at your request, counsel.

Q. Now, the Millon Inventory, and I'll shorten the name, consists of a question sheet containing 175

questions; is that correct?

A. Right,

Q. This file contains the original answer sheet as completed by Mr. Reda?

A. Correct.

Q. This Millon Inventory also contains a sheet that has a graph on it?

A. Yes.

Q. And then approximately six pages of typed material, which appears to be some sort of a report?

A. Correct.

Q. Who generates the graph and the report?

A. It's a computer scoring service, I believe, in Minnesota.

Q. Do you have any input into either the compilation of the graph or the preparation of the report or the Millon Inventory?

A. No.

Q. And both the graph and the report itself is generated by a computer?

A. Correct.

Q. To your knowledge, is there any input in the preparation of the graph or the report by humans, other than the preparation of the computer program and so forth?

A. No. It is a computer-generated profile and report.

Q. Am I correct in understanding, then, that the answers that Mr. Reda marks on the answer sheet are simply fed into a computer, and then the computer generates, on its own, the graph and the report?

A. Correct.

Q. Is the report reviewed at all by anybody at the -- well, where is it --

A. I think it's the National Computer Services, something like that.

Q. All right. National Computer Systems?

A. Right.

Q. Does anybody at that particular company or.. entity review the graph or the report before sending it on to you?

A. I don't know.

Q. Once you get it, you review it, correct?

A. That's right,

Q. Have you made any changes in the report or the graph?

A. None.

Q. Do you agree with all of the findings in the graph or all of the -- I guess you would call them

findings or compilations in the graph?

A. The -- my answer in terms of the graph is yes, I agree with all of those because the graph is just a reflection of score totals. It's a little bit like asking do I agree with everything on an x-ray, and the response to that would be that that's a photograph of the innards of the person. So yes, the graph is just a compilation of scores objectively added and multiplied and weighted, so yes.

The other point worth making is that there are so-called validity checks within the computer program that try to make certain that there weren't errors in terms of the way the person took the test; in other words, the computer's wired to detect certain errors. It, the computer, went ahead and described that profile as a valid report, so that suggests also that it is, in fact, correct.

Q. The findings in the report, the typed report, do you agree with all of the findings in that?

A. I agree with it in general. There are places where I have to make a choice. For example, there's one place where the report says that this profile applies to two different populations, and I, then, as the clinician, have to choose which population this particular narrative

report fits.

Q. Without -- I'm sorry, go ahead.

A. Yeah. And so I, in that case, I agreed with the second as opposed to the first population of people mentioned in the report.

Q. Without going to specifics at this time, other than what you have just described for me, do you agree with the findings in the report?

A. Yes, for the most part. There may be some sentence, something that I'm not thinking about right now, something that I also don't agree with, but at this moment, all I can think of right now is what I just described to you.

Q. So I'm correct in understanding, the part that you disagree with is the selection of the two groups that are specified in the report?

A. It says on some page -- and I don't have the report in my hands right now -- but fairly early in the report, it says this profile describes one of two groups. It describes the first, and then it describes the second, and I'm saying as I recall, I apply the second description and not the first.

Q. And that is the same group that was chosen in the report itself, correct?

A. The report describes two groups, yeah, and so sort of asks me to choose one of the two.

Q. Okay. Your report also contains what looks like an MMPI profile, and in the same line it has "P13" and then "RPT"?

A. Right.

Q. Could you tell me what that is?

A. The graph that you're holding up appears on page 13 in my written report. It is reduced, but that is the graph that appears on page 13 in my RPT. That is "report".

Q. The lines that are on there are obviously the graphs of the MMPI results, correct?

A, Correct.

Q. Am I correct that the dark solid line is the result of Mr. Reda's MMPI that he took for you?

A. Correct.

Q. The other two broken lines represent the MMPI results for two separate studies --

A. Correct.

Q. -- that you have used as a basis of eomparison?

A. Correct.

Q. Okay. There is also what appears to be a

MMPI profile entitled Reda, and then again, "P7", and "report". Can you identify for me what that is?

A. These are two profiles, both generated by Psychologist Lahner, L-a-h-n-e-r, and I simply reproduced both of her obtained profiles on one sheet, and the label at the top is -- refers to the fact that that particular graph is copied and reproduced in my report on page 7.

Q. The broken graph line represents the MMPI that was taken by Mr. Reda on February 9th, 1990; is that correct?

A. That's correct.

Q. And then the solid graph line represents the MMPI that was taken by Mr. Reda or November 14th, 1990?

A. Correct.

Q. Is it your testimony that the results of those MMPI's are accurately reproduced on the graph that is in your file that we have been talking about?

A. I believe they are.

Q. Okay.

(Discussion was had off the record.)

Q. Dr, Layne, I have in my hand a packet which I have reviewed of several letters and correspondence to you from Mr. Moran and to myself and so forth. There's a letter from Mr. Moran to you dated February 27th, 1991,

advising of the enclosure of Dr. Lahner's report, her two reports, and the million multiaxle inventory, and a Geauga Hospital report on Mr. Reda. I take it you reviewed all those in preparation for your evaluation of Mr. Reda?

A. Correct.

Q. Has Mr. Moran supplied you with any records other than those of Dr. Lahner and those of Geauga County Hospital?

A. All records that he supplied are in the file.

MR. MORAN: For the record, Joe, in the doctor's report, he states that he's reviewed the Geauga County emergency record and Dr. Margaret Lahner's report. That's in Dr. Layne's report.

Q. Dr. Layne, have you reviewed any other reports besides Dr. Lahner's records and Geauga County Hospital?

A. The newspaper articles on Mr. Reda's difficulties with his employer.

MR. DeROSA: I'm going to move that Dr. Layne's reference to the newspaper articles of Mr. Reda's trouble with his employm'ent, as Judge Inderlied has already indicated, that any such reference is not admissable in

this record,,

MR. MORAN: I'll object.

Q. Go ahead. Any other documents that you reviewed?

A. There is, as I recall, some medical reports. Perhaps that is the Geauga Hospital record that you have already mentioned. There's an x-ray report within that set of medical reports. Again, it's contained in the file that you have in your hand.

Q. Okay. Does the report that you generated for Mr. Moran contain a complete list of all the materials that you reviewed?

A. I believe that it does.

Q. .Since the time, that you reviewed those materials and conducted your evaluation of Mr. Reda, have you obtained any additional materials?

A. I don't think so, no.

Q. Doctor, your file I've just turned over, and it contains the Geauga County Hospital records, and you have highlighted certain portions of the Geauga County Hospital records.

A. Yes.

Q. Could you tell me why you highlighted those parts of the record, and I'll hand that to you so you can

take a better look at it.

A. In a general way, I have highlighted, of course, the things that are particularly important within the documents, particularly important to me. The date of the record is, of course, important, just to orient me in terms of when it was written and the author. I almost always highlight the author's name so that I know who generated the document, and beyond that, I have to go sort of phrase by phrase and tell you why each of these is important, and I'm happy to do that.

Q. Is it fair to say that the body of the record that you highlighted, the triage notes, were important to you in your evaluation of Mr. Reda because it describes the occurrence which lead to his injuries, and also describes the injuries *that* he sustained in that occurrence?

A. Yes, yes, this was an important record.

Q. All right. And you also have highlighted the radiology report or the x-ray report, and I take it that was important to you because it describes the fact that no foreign body was noted in the leg and no fracture or other boney abnormality was seen in the leg?

A. Yes.

Q. Is the Geauga County x-ray report important

to you for any other reason?

A. Well, in a general sense, it is another measure of the severity of the injury.

Q. On the -- what appears to be the last page of the Geauga County Hospital record, you have the admit date and time highlighted, correct?

A. Right.

Q. Why is that important to you?

A. Well, I want to confirm when he was hurt and roughly what time he made it to the emergency room.

Q. Well, that date and time does not specifically refer to the time that he was hurt, but to the time that he was admitted to Ceauga County Hospital; is that correct?

A. Maybe I should look at it more carefully to make sure.

Q. Okay. I'll hand you the report back, The date and time that appear highlighted at the very top of that page, that was the admit time and the admit date to Geauga County Hospital; is that correct?

A. Exactly.

Q. Why is that important to you?

A. Because it helps to, once again, tell me what this record is all about, when it occurred, that sort of

thing.

Q. When you say "when it occurred", does that mean when the record was generated?

A. Right, and when the person came into the hospital, yes.

Q. Okay. And there are also some other lines highlighted. You have the date of birth highlighted?

A. Yes.

Q. Is that important to you?

A. Yes.

Q. In what way?

A. Because it tells me how old he is and gives me a reference point in terms of the events of his life.

Q. Is Mr. Reda's age important to you for any specific reason?

A. In a general way. It helps me to peg when things in his life occurred, from beginning to end.

Q. Does that assist you in taking a history, or does that assist you in making a diagnosis?

A. In making a diagnosis.

Q. What role does his age or date of birth play in making a diagnosis.

A. Well, just to give you a few examples, a personality disorder cannot exist until the person is 18.

The average age of onset for mania is roughly 30, so -- you know, I could go on and on. There are different ages when different mental health difficulties are more likely to arise.

Pre-senile dementia doesn't arise in someone who is 20. It arises in someone who is 40 or 50 or something like that, so that's the reason to get to know how old the person we're dealing with is.

Q. Does Mr. Reda's age play an important role in the diagnosis that you arrived at in this particular case?

A. It played a minor role in this particular case.

Q. And can you explain to me why it played a minor role?

A. Because the diagnosis that I came up with, as I said, relates to a personality disorder. He had to be beyond 18 years old to be eligible for that diagnosis, and the age was really not relevant to the diagnosis other than that problem.

Q. His age would not be relevant to a diagnosis or a non-diagnosis of post-traumatic stress disorder, would it?

A. I don't think so. A person with post-traumatic stress disorder can be --

Q. It can be a child?

A. Right, right. Four-year-old, could be a hundred-year-old, yes.

Q. Now, you also have highlighted on the Geauga County Hospital record the last page, "bullet wounds, upper right thigh". Again, that's important to you because it describes the type of injury that was sustained?

A. Correct.

Q. You have highlighted "person to notify, neighbor". Can you tell me why that was important to you?

A. I think that we first focused on the name, Bob Warentis, wondered who he was, and then looked above, saw that it was a neighbor, and so we highlighted that to tip us off that this was not an important piece of data. We missed that on our first go-round.

Q. When you say "we", who are you referring to?

A. Myself and one secretary or another who might help in going over the documents originally, in order to make sure that they're all in order, that sort of thing.

Q. The secretaries that you use to assist you, what role do they play in your evaluation of a person such as Mr. Reda?

A. They will receive the documents; by that, I

mean they will open the envelope, pull out the documents. Sometimes they will highlight, for example, the date that the document was generated, the person who wrote the document. They do that for me before I go over them.

Q. That's a standard routine in your office that --

A. Yes.

Q. -- that they have been instructed to follow?

A. Often, yes, yes.

Q. And then the last thing on the page that you have highlighted is Mr. Reda's wife's name, Margaret.

A. Right.

Q. And was that important to you for any particular reason, or just because you need to know what his wife's name was?

A. Often as you review the records later, there will be reference to the person's wife, but you won't know -- out of context you won't know who they're referring to, so it's sort of good to get to know the names of the family.

Q. Doctor, your file also contains the billing statements of Dr. Margaret Lahner, Mr. Reda's treating psychologist; is that correct?

A. That's correct.

Q. And these documents show that Dr. Lahner treated Mr. Reda from November 14th '88 through February 9th, 1990; is that correct?

A. Let's see. From November of '88 until August of '89. On the next page, there are some additional treatment sessions in 1990.

Q. What is the last date of treatment?

A. On this document, the last date of treatment is February of 1990.

Q. Okay. Your file also contains the July 31st, 1989, report of Dr. Margaret Lahner?

A. Correct.

Q. And the MMPI profile for the test taken November 14th, 1988?

A, That's correct, which Dr. Lahner cites in that particular report.

Q. Your file contains the report of Dr. Lahner dated April 9th, 1990, along with the August 24th, 1990, addendum advising of the typographical error, correcting post-dramatic stress disorder to post-traumatic stress disorder; is that correct, Doctor?

A. Yes, it is.

Q. And it has an attachment of the MMPI taken by Mr. Reda on February 9th, 1990, the profile?

A. That's correct, and she cited that in that document.

Q. Doctor, your file contains another MMPI that is -- profile, an MMPI profile that is entitled Reno Reda --

A. By CCL, that's me.

Q. That's yourself?

A. Right. Included with post-traumatic stress disorder profiles, In other words, that was our -- my -- that was the MMPI that Mr. Reda took from me. I made that profile and then transcribed it on to the profile of post-traumatic stress disorder victims, which we've already discussed.

Q. All right. Doctor, I was not provided a copy of *this* MMPI profile for the test that you administered to Mr. Reda. Do you have any objections to me getting a copy of this?

A. No --

MR. MORAN: Excuse ne, which one?

A. And I would be surprised if you were not.

MR. DeROSA: This is the MMPI profile that Dr. Layne administered.

MR. MORAN: Is that in your report?

THE WITNESS: It is in my report.

MR. DeROSA: Yeah, but I don't have -- if there's no objection, I would just like a copy of this profile.

MR. WORAN: No objections.

A. Yes.

Q. You're the one that charted the profile; is that correct?

A. A secretary made the chart.

Q. And how does that secretary go about making this chart?

A. She first scores the questions using standard templates. That process involves laying templates over the sheet that's in your lap there, the sheet with all the dots on it --

Q. The sheet with all the dots on it is the answer sheet?

A. Correct.

Q. That I have been provided with, all right.

MR, MORAN: Can we go off the record.

(Discussion was had off the record.)

Q. Doctor, you have made a copy of the MMPI profile for the MNPI administered by yourself to Mr. Reda; is that correct?

A. That's right,

Q. You've been kind enough -- apparently the copy machine cut off the bottom row of numbers, and you've been kind enough to write those on there for us in blue ink.

A. Correct.

Q. And you're telling me that it's your secretary who takes the answer sheet that Mr. Reda fills out and then she uses a template to score the test and then transfer those scores on to the graph?

A. That's right.

Q. And then she is the one that actually plots the graph, places the dots in the appropriate locations, and then connects the dots?

A. Correct.

Q. Okay. Did you review Mr. Reda's answer sheet and the graph, the MMPI profile, to insure that it was correct?

A. I don't think so.

Q. As a matter of routine, do you usually review to make sure that it is correct?

A. I do spot checks, maybe one out of four or one out of six that is scored, to make sure that they're continuing to be accurate.

Q. Do you recall whether or not you spot-checked

Mr. Reda's?

A. I don't believe that I did.

Q. Okay. Finally, Doctor, your -- or excuse me, your file contains the, or copies, at least, of the handwritten office notes of Dr. Lahner on Mr. Reda; is that correct?

A. Correct.

Q. And you have highlighted certain areas of her records, some in blue and some in yellow?

A. Correct.

Q. All right. What is the difference between the yellow highlighting and the blue highlighting?

A. Yellow is general information that we -- that I might need to know. Blue pertains to specific mental-health related information, so that's the difference. Blue signals us this has something to do with psychologieal makeup.

Q. And yellow is just background information or historical information on the individual?

A. Right, right.

Q. And then the blue would pertain, in your opinion, specifically, to the problem or problems for which you are evaluating him?

A. That's right, or any other problems, right,

psychological problems.

Q. Doctor, thank you. I'm going to hand your file back to you.

A. All right.

Q. Mow, Doctor, are there different MMPI's that can be administered?

A. Yes. Today there are two, the MMPI-I, and the MMPI-II.

Q. Which one did you administer to Mr. Reda?

A. The MMPI-I.

Q. I noticed in your file that it did not contain the actual questions themselves.

A. Correct.

Q. Do you have those questions for me so that I can get a copy of them?

A. Yes, I'd be happy to give you a so-called test booklet.

MR. MORAN: For the record, I made a copy of that at your request and gave it to Reno Reda the day of his test,

MR. DeROSA: The test booklet itself?

MR. MORAN: Yes.

MR. DeROSA: With the questions in it?

MR. MORAN: Yes. And I copied the

answer sheet, which wasn't graded, obviously, because as soon as he completed the test, I copied the answer booklet at your request so he could take it to your office.

MR. DeROSA: So that's what the test booklet was that he used while he was taking the MMPI at your office?

MR. MORAN: Correct.

MR. DeROSA: Okay, fine. In that case, Doctor, I don't need for you to supply that for me.

THE WITNESS: Could I add that the MMPI, it is all over the world. It is -- you can get these questions from any psychologist. They are very standard questions.

Q. The MMPI-I has a standard set of questions so that any psychologist administering it to any person would be using the same set of questions?

A. Correct.

Q. They are in the same order?

A. Precisely the same questions.

Q. And they are graded precisely in the same manner?

A. The -- some get it scored by computer, some get it scored by a human, but it is essentially exactly the same scoring, yeah, for the so-called basic scales.

Q. Now, Doctor, we went through your file and we listed everything that was in your file; is that correct?

A. That's correct.

Q. Did you generate or provide any reports to anybody on Mr. Reda other than the one report that is in your file there?

A. NO.

Q. I also noted that there's no notes of your personal interview with Mr. Reda.

A. Correct.

Q. Why is that?

A. I tend to write reports relatively quickly, and so I -- I bring a dictaphone to the evaluation session and will often do some dictating while I'm right there in the room, for example, when the person is taking the test, during breaks, that sort of thing, so I don't really have need for the few notes that I sketch out in hand.

Q. You do make handwritten notes while you are interviewing the individual?

A. That's right.

Q. In fact, you made handwritten notes while you were interviewing Mr. Reda.

A. Correct.

Q. Did you make any handwritten notes while Mr. Reda was taking either the MMPI or the Millon?

MR. MORAN: For the record, Dr. Layne was not present when that test was taken.

MR. DeROSA: That I didn't know.

MR. MORAN: That's why I made copies of the test at your request, and then Dr. Layne came -- I think the test was administered at noon and Dr. Layne arrived like at 3:00 or something.

THE WITNESS: Right.

Q. Is that accurate, the tests were administered before you actually got there?

A. They were *at* least begun before I got there. You know, it could be that when I got there, he was finishing up.

Q. Who explained to Mr. Reda how to take those tests?

A. Well, they are self-administering. The instructions for taking the test are right on the front of the test, and, in fact, to preserve standardization, it's

really unwise for people to tell the test-taker how to take the test. The instructions are "Read the instructions and then take the test."

Q. Now, this evaluation and your personal interview was conducted at Mr. Moran's office; is that correct?

A. Correct.

Q. The attorney representing the defendant in this case.

A. Correct.

Q. Do you know who handed the materials to Mr. Reda?

A. NO.

MR. DeROSA: Mr. Moran's pointing to himself.

MR. MORAN: For the record, I thought you and I were aware -- or you were aware of exactly how this was done, because you discussed it prior to its being conducted.

MR. DeROSA: Yeah, but I didn't know exactly who handed it to him.

MR. MORAN: For the record, Mr. DeRosa and I discussed that Mr. Reno Reda would come to my office, exact time, I don't remember,

9:00 or the 10:00 in the morning, he would come to my office to take this test. Mr. DeRosa did not come pursuant to agreement because he had other matters to attend to. Dr. Layne was not there also, and again, that would be €or economic reasons.

Mr. DeRosa wasn't there because he was on an hourly rate someplace else, and Dr. Layne wasn't there because he was on an hourly rate someplace else.

When Mr. Reda came into the office, I greeted him, offered him a cup of coffee. He went into the one of the attorney's offices; the desk was cleared; he was given a couple pencils and a test booklet and a cup of coffee. He sat behind the desk, and as the doctor said, I indicated to him, Here are the tests. Read the directions, and, you know, have at it. That was --

MR. DeROSA: You were the one that actually gave him the materials?

MR. MORAN: I handed him the materials.

MR, DeROSA: Was there another individual, a secretary or another attorney

who actually was involved in the process?

MR. MORAN: No, there was no one else in the room with him. I put him in the room and closed the door, and he came out after maybe an hour or so and asked for another cup of coffee, which he got, but he was in the -- in an office by himself.

Q. Okay, The notes that you did make, the handwritten notes that you did make, were those all made during your personal interview of Mr. Reda?

A. Yes.

Q. And how soon after that interview was concluded did you dictate your report?

A. The -- the part that involves my notes is were -- I dictated them that day. When I get back to the office, I go right into dictating what I saw that day because it's all very fresh in my memory, and my routine in all cases is to do that and then toss the notes away.

Q. Did you dictate your handwritten notes verbatim?

A. No.

Q. Did you leave portions of your notes out of that dictation and out of your final report that you issued for Mr. Moran?

A. I'm sure I did in that those notes are sloppy, some random, some, as it turns out, not relevant.

Q. When you treat patients here in your office, you make handwritten notes?

A. Correct.

Q. Do you destroy those as well?

A. No.

Q. Those you keep?

A. Correct.

Q. What is the purpose in destroying the notes, then, that you make when you're doing an evaluation in a legal setting?

A. Well, if I -- maybe we can look at it from the other angle. If I were to dictate notes from my handwritten notes on the same day with a patient, I would then throw away the handwritten notes. Similarly, in this case, the point is that I have a typewritten record of exactly what was told to me, what the person's behavior was like and so on, so it's redundant to keep the handwritten notes.

Q. Well, Doctor, you have indicated already that you do not verbatim dictate what your handwritten notes contain; is that correct?

A. Correct.

Q. You know that in a legal setting such as this, those notes would be important not only to the attorneys, but to the jury, and to, perhaps, another expert, do you not?

MR. MORAN: Objection.

A. I wouldn't think that those notes would be as important as the more formal typewritten rendition of my memories and --

Q. You found Dr. Lahner's notes particularly important, did you not?

A, Yes, I did.

Q. But yet you don't think your notes would be particularly important to anybody else?

A. If -- no, in that as I have said, I dictated my handwritten notes on the same day.

Q. Well, what did you leave out of your report and your dictation from those handwritten notes that you took during the interview of Mr. Reda?

A. Very little. The report is, of course, more than the handwritten notes. It is the documents that I reviewed, the test data and conclusions which are not drawn via the handwritten notes, but I leave out very little.

I mean, the -- you're asking me if I

literally verbatim copy the notes, and, of course, that's not true. The notes are shorthand, as it were. Furthermore, there may be things in the notes that are -- that remind me to look at some other document or notes to myself, and those are not really relevant to the report. But I guess the point I'm trying to make is that the report, I believe, covers just about everything -- in fact, everything of importance that I wrote down.

Q. How do you or anybody else looking at your report know whether or not you've dictated accurately off of your notes if you destroy them?

A. The -- I don't suppose that they can. I mean --

Q. So, in other words, we, meaning other people who may look at your report, simply have to rely on your word that what you put down in your report is accurate?

A. That, of course, is true for every health care professional and in this case, too.

Q. But Dr. Lahner, on the other hand, has her handwritten notes, so we can go back and we can check what she puts in her report with what she puts in her handwritten notes?

A. That is true, yes.

Q. Wouldn't you agree that that's at least a

little bit more valid as far as a check on validity of the report?

A. Well, no, I don't. If Dr. Lahner told me that she took some handwritten notes and on that very day, she translated those handwritten notes in the typed form and threw away the handwritten notes, I would think that would be pretty credible.

Q. Row often with your own patients do you throw away ycur notes and dictate that very same day?

A. I never do handwritten notes on my patients and then dictate from them. I leave it as handwritten notes. In this case, if I were to have known that I was going to submit just my handwritten notes, which is the case with my patients, then, of course? I would have kept them.

Q. Doctor, you have testified previously in legal matters, correct?

A. Correct.

Q. You have evaluated many people before in a legal context, correct?

A. That's right.

Q. You have had your deposition taken many times in legal matters, correct?

A. That's right.

Q. Do not most attorneys, when they take your deposition, ask for your handwritten notes?

A. Many do.

Q. Isn't that a good indication to you that other people find your notes important and that you should keep those handwritten notes?

A. Well, when I give this explanation that I contemporaneously dictate from the handwritten notes, they are universally satisfied with that explanation.

Q. Do you find anything objectional to handing those things over to anybody?

A. No, not at all. The only thing I find objectional is taking up file space with sloppy handwriting. It's a little bit like saving a grocery list, you know, when it's already been *done*, When you got the groceries, why should keep your grocery list.

Q. How many pages did you generate on Mr. Reda's handwritten notes based on your evaluation?

A. The equivalent, probably, of ***two*** legal-size pages.

Q. So two pieces of paper?

A. Right. Now, there may have been more than two pieces of paper involved because often I'll have three or four pieces of paper laid out, one for the person's

behavior, one for historical information, maybe one for something else, but they weren't filled.

Q. So you would -- your best recollection is that you would have four sheets of paper with handwritten notes on those pages?

A. Say half a page each.

Q. Each?

A. Yes.

Q. Okay. And your testimony is that that's too much paper to keep in a file and to store?

A. That's correct. There's just no reason for it.

Q. The materials that we went through in your file, the records from Geauga County Hospital and the records of Dr. Lahner's reports, the MMPI's, and her handwritten written notes were reviewed by you before you evaluated -- or excuse me, before you interviewed Mr. Reda and the tests were administered to him; is that correct?

A. That's correct.

Q. Did you review any additional materials or information on Mr. Reda after you interviewed him?

A. The -- I believe I received the newspaper articles at the time of the interview.

MR. DeROSA: Again, I would interpose

my objection and move that it be stricken.

MR. MORAN: I object to his objection.

A. No other records after the interview with Mr. Reda that I can recall.

Q. Other than the report that was supplied to Mr. Moran and the report that was supplied to me, and I believe it's dated March 14th, if I am correct, presented on March 14th, 1991 --

A. Right,

Q. -- did you prepare any other materials or reports?

A. NO.

Q. Did you review any authoritative textbooks, articles, studies, either before or after evaluating or interviewing Mr. Reda specifically for Mr. Reda's case?

A. I think that I reviewed, reacquainted myself with much of the literature that I cite in the report. I had already been familiar with 99 percent of what I have cited in that report, but, of course, I had to refamiliarize myself with it.

Q. Are all the materials that you reviewed or refamiliarized yourself with listed in your report?

A. Probably so, yes.

Q. Was there any material or information that

you requested from Mr. Moran or from any other sources that you did not get on Mr. Reda?

A. No.

Q. Did you specifically request that Mr. Moran obtain for you any materials or information on Mr. Reda?

A. I routinely ask attorneys who want my input to give me as much as they can in the way of written records.

Q. Did you specifically request certain types or categories of records?

A. Again, I don't recall specifically, but generally it is my policy to say send me everything you got, particularly if it pertains to psychology tests, profiles, and that sort of thing, and I suspect that I told Mr. Moran that.

Q. As you sit here today, you don't recall making any specific request of Mr. Moran he provide you with records from Geauga Hospital or records of early childhood treatment or records of employment, anything of; that sort?

A. No. My general policy is to say send me everything you got, and, again, particularly test profiles, raw test data, that sort of thing.

Q. Since your evaluation and interview of Mr.

Reda, have you requested any additional materials from Mr. Moran?

A. I don't recall requesting any since the evaluation.

Q. Has Mr. Moran provided you with any?

A. I'm not quite sure. Perhaps he sent one, something afterwards. I just don't recall. I can look through my file and --

Q. Go ahead, take your time. Let me know.

MR. MORAN: Off the record.

(Discussion was had off the record.)

MR. DeROSA: Back on the record.

Q. Doctor, you've had an opportunity to review your file, so I'll ask you if you received any other materials since you completed your evaluation and interview of Mr. Reda?

A. No, there is no record of any and I recall none.

Q. Are you currently waiting to receive any material on Mr. Reda?

A. No.

Q. Is there anything that you have which is relevant to Mr. Reda's case, meaning information or documents that are -- that is here in your office but not

contained in your file?

A. No.

Q. I don't mean books that you may have reviewed, I'm talking about informational documents that were --

A. On Mr. Reda?

Q. On Mr. Reda.

A. No, no. Everything that I have on Mr. Reda is in that file.

Q. Are there any other documents that you generated in your evaluation or review of Mr. Reda that are here in your office but not contained in your file?

A. No.

Q. Did you talk to Mr. Moran prior to conducting your interview and evaluation of Mr. Reda?

A. Yes.

Q. Do you recall when that was that you spoke with Mr. Moran?

A. In a phone conversation sometime before I examined him.

Q. How many times did you speak with Mr. Moran prior to evaluating and interviewing Mr. Reda?

A. I believe once.

Q. Did you speak with anybody else representing

the defendant Mrack id other than Mr. Moran prior to conducting your interview and evaluation of Mr. Reda?

A. No.

Q. So Mr. Moran would be the only person you have ever spoken with representing Mr. DuGuid?

A. That's correct.

Q. How long did your conversation with Mr. Moran last?

A. I'm going to have trouble remembering it, and so I'll tell you in a general way that the conversations that I have typically run 15, 20 minutes. I really don't recall that specific phone conversation.

Q. Okay. Do you recall any information that Mr. Moran supplied to you or any statements that Mr. Moran made in that conversation with you before your evaluation and interview with Mr. Reda?

A. No. I remember in the most general way him describing the case, that is to say that he had a case that involved someone getting shot, and that he wanted to -- for me to examine this person to see whether or not the incident had an impact on his mental health.

Q. Did Mr. Moran convey to you his version of the facts of the shooting in that conversation?

A. Right. I don't recall, but I don't think so,

no. I have not -- I don't really remember.

Q. In that conversation that you had with Mr. Moran, did he express any opinion to you about the merits of the case on behalf of Mr. Reda?

MR. MORAN: I would object, attorney-client privilege. You can answer if you remember.

MR. DeROSA: Excuse me, Mr. Moran. Are you saying that you represent Dr. Layne?

MR, MORAN: No, no, I'm not.

Q. All right. Did Mr. --

A. I really don't recall that brief phone conversation well enough to say, but I doubt it. I would remember, I think, if he had mentipned something like that,

Q. Do you recall Mr. Moran giving you any description or offering you any opinion of Mr. Reda himself in that conversation?

A. I don't think so.

Q. And again, it's your best recollection that that conversation would have lasted 15 to 20 minutes?

A. That's about right. That's the routine amount.

Q. And you cannot recall precisely when that

conversation would have taken place?

A. That's right.

Q. It would have been a phone conversation?

A. Yes,

Q. Do you know who initiated that phone conversation?

A. Again, having trouble remembering a phone conversation of many months ago, I'm -- I'm almost basing what I'm telling you now on assumptions. This is the typical way it goes.

Q. Doctor, I don't want you to guess at anything. I'm really not asking you to do that. If you can't recall, just let me know. I just want to know your best recollection, and if you can't remember, please let me know that you can't remember.

A. I really -- I don't remember the conversation.

Q. Are you familiar with the law firm that Mr. Moran is with, Rhoa, Follen & Rawlin?

A. I've been on a case or two with them, I believe.

Q. You have done evaluations for Mr. Rawlin's firm previous to Mr. Reda's case?

A. Yes, at least one.

Q. Do you remember which member of the firm that would have been for?

A. I can look it up.

MR. DeROSA: By the way, it's R-h-o-a, F-o-l-l-e-n, and R-a-w-l-i-n.

A. I have done evaluations -- an evaluation for Mr. Rawlin.

Q. Mr. Ronald Rawlin?

A. Right.

Q. Do you know how Mr. Rawlin came to know about you, how he came to contact you in order to do that evaluation?

A. No, I don't.

Q. Other than the one evaluation for Mr. Rawlin and the evaluation that you did on Mr. Reda in this particular case, have you done any other evaluations for this particular law firm?

A. I may have. It is very difficult for me to remember law firms. I don't -- and so I just don't know.

Q. The evaluation ou did for Mr. Rawlin, that was also on behalf of the defense of that particular case?

A. Yes.

Q. Okay. Mr. Rawlin was defending an individual who had been sued, who had a lawsuit filed against him?

A. I believe so.

Q. In the report that -- or in the evaluation that you did for Mr. Rawlin, you were also supplied with various materials on the plaintiff in that case?

A. Again, I assume so. I'm having trouble remembering the name of the case or the nature of the case.

Q. Is it safe to say that that particular case involved a person who was claiming some type of psychological injury, condition or illness?

A. That's highly probable.

Q. Do you recall whether or not you agreed with that individual's treating psychologist or physician as to the existence of that particular psychological illness, injury, or condition?

A. I don't recall.

Q. Now, what was the date of Mr. Reda's evaluation?

A. It was March 8th, 1991.

Q. And that was performed in Mr. Moran's office in Cleveland, Ohio?

A. Correct.

Q. And your office is here in Toledo?

A. That's right.

Q. Mr. Moran stated earlier on the record the reason it was done that way -- I don't know if you did state that. Why was the evaluation performed in Cleveland rather than Toledo?

A. I really don't know.

Q. Do you go to Cleveland on occasion to do evaluations?

A. Yes.

Q. How often do you go *to* Cleveland?

A. It varies widely, but I have probably been in Cleveland four times, five times during my career.

Q. And your career spans how many years?

A. Sixteen years.

Q. So you've been to Cleveland for purposes of doing evaluations --

A. Correct.

Q. -- approximately four or five times?

A. Right.

Q. Do you travel to other cities other than Cleveland to perform evaluations?

A. Yes.

Q. How often do you travel to other cities outside of Toledo in order to perform evaluations?

A. It probably averages to, say, six times a

year, four to six times a year, say.

Q. Four to six times per year that you travel outside of Toledo to conduct evaluations, psychological evaluations?

A. Right.

Q. Now, did you ever see Mr. Reda before March 8th of 1991?

A. No.

Q. And your purpose in seeing Mr. Reda on March 8th, 1991, was not to treat him, was it?

A. That's right.

Q. It was to evaluate him for purposes of this lawsuit?

A. Correct.

Q. And you were asked to evaluate him by the defendant's attorney, correct?

A. Right.

Q. You told Mr. Reda precisely that, did you not?

A. Yes.

Q. You told Mr. Reda that you were not there to help or to treat him?

A. Right.

Q. And that you were evaluating him for purposes

of his lawsuit.

A. Right.

Q. And you told him that your evaluation could possibly hurt his lawsuit?

A. Right.

Q. And that was the one and only time that you saw Mr. Reda, correct?

A. Correct.

Q. How long did you actually meet, see, and talk with Mr. Reda on March 8th, 1991?

A. Approximately two hours, face to face.

Q. Face to face?

A. Right.

Q. Were there any breaks during that two-hour period where anybody left the room and used the rest room or got a drink of water or stretched their legs?

A. Yes, at least once, as I recall.

Q. How long did that break last?

A. I don't know. I can only assume five minutes, ten minutes --

Q. Ten minutes?

A. Five minutes is more like it.

Q. Five to ten minutes, somewhere around there?

A. Uh-huh.

Q. So your actual face-to-face interview with Mr. Reda lasted approximately two hours?

A. Right,

Q. And that would be the extent of your contact with Mr. Reda?

A. The extent of my face-to-face contact, right.

Q. Face-to-face contact with Mr. Reda?

A. Right.

Q. Do you know how many times Dr. Lahner saw Mr. Reda?

A. According to records, approximately 15 or so.

Q. You have her billing statement there which lists the dates of her treatment, right?

A. Right.

Q. Why don't you take a look at that and see how many times Dr. Lahner saw Mr. Reda,

A. There are six sessions total.

Q. And those sessions begin on what date?

A. November of 1988.

Q. So that would have been approximately two months after the shooting incident involving Mr. Reda; is that correct?

A. That's right.

Q. To your knowledge and belief, is Dr. Lahner a

competent psychologist?

A. I really don't know Dr. Lahner, and, therefore, cannot say. I've never heard of her, and shouldn't have. She practices in Chesterland, Ohio, so...

Q. Do you have any reason to believe that she is not a competent psychologist?

A. No,

Q. Assuming that she is a competent psychologist, and assuming that she has seen Mr. Reda approximately 25 times beginning two months after the shooting and extending into February of 1990, wouldn't she be in a better position to evaluate Mr. Reda's condition at the time that she was actually seeing and treating him?

A. That would appear to be the case, yes.

Q. Do you accept Dr. Lahner's recitation of the history that she obtained from Mr. Reda and accept her recitation of the complaints that he presented as set forth in her notes and her report?

A. As set forth in her notes and her report, yes, I took that historical information seriously and as accurate and verified it with Mr. Reda.

Q. So her report and her notes as verified by yourself appear to be true and accurate?

A. Her -- what I'm saying is her rendition of

his history --

Q. Now, his history would include his childhood illnesses, diseases, where he attended high school, where he attended college, his work history, information about his family, correct?

A. Right.

Q. All that information that you saw in Dr. Lahaar's note and report appear to you to be accurate?

A. Well, "all" is too strong a word. There were inconsistencies that troubled me, and I mentioned those in my report. At times she said things that were, in my mind, incompatible.

Q. Well, I'm not speaking about any conclusions that she drew.

A. Right.

Q. I'm just talking about when she wrote down the history.

A. Yes.

Q. Does that appear to b accurate?

A. Well, no. For exampl --

Q. Use your report or wh tever other records you have.

A. Okay. There's a place in her report -- it is in her July 31st, 1990, report, page 2, paragraph 3,

toward the bottom, quote, "There is nothing in the history to indicate any drug abuse problem," period, unquote.

Q. Is there anything else in the history that you disagree with other than what you have just quoted for me?

A. I'm not sure. I would have to -- but that's the one that I recall very clearly.

Q. Okay. Well, take this opportunity, review her reports and her notes and tell me if there's anything else in her recitation of Mr. Reda's history that you disagree with.

A. Okay. I have no disagreement that I can find in the July 31st, 1990, report, no other disagreement with what she has said.

Q. All right. Please review her April 9th, 1990, report as it pertains to the recitation of the history, and please also review her handwritten office notes and let me know if you have any disagreement with the history.

A. Okay. I disagree with her report of April 9th, 1990, as regards her interpretation of his risk-taking, but that's not really historical, that's an interpretation of his history, and so maybe I should save that.

Q. Setting aside her interpretation, what I'm interested in is merely her recitation of the history.

A. All right.

Q. Is there anything in her April 9th, 1990, report in the recitation of the history that you disagree with?

A. No. In terms of the history, the factual content of this history, I see nothing else that I disagree with in that report,

Q. Please review Dr. Lahner's handwritten notes. Tell me if there is anything in the recitation of Mr. Reda's history that you disagree with or you find inaccurate?

A. The only other thing that I can think of is that occasionally in each of *these* documents, as I recall, Mr. Reda will comment on his anxities or his depression, and again, I consider that to be Mr. Reda's self-interpretation of his own life, therefore, not a part of the history. But no, I see nothing in the handwritten notes that I disagree with in terms of his factual history.

Q. You've had an opportunity to review those notes. We sat here while you reviewed them and you're satisfied with your answer?

A. Yes.

Q. Okay. Now, you indicated that your personal interview with Mr. Reda took approximately two hours. How long did it take you -- is that correct?

A. Yes.

Q. How long did it take you to review the records that Mr. Moran provided to you?

A. Say four hours,

Q. And that was done before *you* had the personal interview with Mr. Reda?

A. Yes.

Q. Do *you* know how long it took Mr. Reda to take the two tests, the MMPI and the Millon, M-i-l-l-o-n, tests on March *8*, 1991?

A. No, I guess I don't.

Q. Did you ask anybody, either Mr. Moran or somebody in his office, **to** keep track of how long it took him to take either of those two tests?

A. No.

Q. Is that important to you at all?

A. No, not particularly.

Q. Does the length of time that it takes a person to complete the MMPI have any bearing on your interpretation of that test?

A. It can be relevant in the extremes.

Q. What would be the extremes that would be relevant to you?

A. If it took a person, say, three hours to take just the MMPI, you would wonder why it took so long.

Q. If a person did take three hours to complete the MMPI, what would that indicate to you?

A. It could mean that the person was mentally retarded, brain damaged, grossly depressed, something like that.

Q. Go ahead. Why else would the time -- the extremes in taking the test, the MMPI, be relevant to you?

A. That's really about it.

Q. What happens if it -- what's the normal? What would be considered the normal amount of time it would take to take the MMPI?

A. An hour and ten minutes,

Q. If a person took considerably less than an hour and ten minutes, would that be relevant to you?

A. Well, none of these time factors are very important, If it took him less time, it might mean he's a little brighter than average, functioning psychologically relatively well.

Q. If it took considerably less or considerably

more than an hour and ten minutes to complete that test, would that enter into your overall evaluation and diagnosis of that particular person's condition or lack of psychological condition.

A. If the range was -- let's say if the person took less than 40 minutes or more than, say, two-and-a-half or three hours, it would be of mild interest, that's all.

Q. No more than mild interest?

A. That's right.

Q. Okay. Did you have anybody observe for you Mr. Reda while he was taking either the MMPI or the Millon test?

A. No.

Q. You, yourself, did not observe Mr. Reda while he was either taking the MNPI or the Millon test?

A. Correct.

Q. You obviously observed Mr. Reda while he was in the personal interview with you, correct?

A. Of course.

Q. You observed his mannerisms, his dress?

A. Right.

Q. His appearance, his mood, all those things?

A. Correct.

Q. What observations did you make of him during that interview?

A. What was striking is his relative fearlessness, his boldness, his strength of character. He was assertive, not timid, not anxious, not depressed. Again, not just average on those dimensions, but rather unusually calm, unusually assertive.

Q. Did you make any other observations of Mr. Reda while he was in the personal interview with you?

A. Yes.

Q. In fact, you're referring to your report ROW?

A. Yes, I am.

Q. To what page of your report are you referring?

A. Page 6.

Q. What other observations of Mr. Reda did you make during your personal interview with him?

A. That he had an edge of hostility. By "edge" I mean it was miner, but he was more hostile than passive. He also seemed somewhat evasive. He gave me a few inconsistent statements, like sayinq that he couldn't remember much about the incident, and then turning around and giving me the shooting incident in very fine detail. There were times where he said he had bad dreams, and so I

inquired about the nature of those dreams, and his response was that they were abstract; and so I asked him what was an abstract dream like, and his response was to sort of say that he couldn't really describe it. I mean, it was difficult for him to describe the dream. It was disturbing. He was indicating that the dream had come from the shooting incident, but he couldn't describe the dream, I was sceptical about that, it seemed evasive to me, so evasive is another thing,

Q. Did Mr. Reda ever refuse to answer any questions €or you?

A. No, he never blatantly said I'm not going to answer that, no.

Q. Now, you earlier made reference to Mr. Reda being mildly hostile?

A. Right.

Q. Now, is that what we -- laymen would equate to being defensive?

A, Yes, that's another fair term for it.

Q. Okay. Did you find that unreasonable concerning -- or considering the circumstances that Mr. Reda was in and what he was there for and the purpose he was there for?

A. Well, some people -- I found it unusual even

for that circumstance, yes, unusual.

Q. In what way?

A. Well, there are many people who suffer from anxiety disorders who are timid in that situation. They are intimidated by it: they're awed by it.

Q. You're speaking about people who are in the acute phase of the anxiety disorder, correct?

A. Right, right, or -- well, people who have anxiety disorders.

Q. Mr. Reda did not have an anxiety disorder at the tine that you evaluated him, did he?

A. That's correct, he did not,

Q. Okay. Now, considering the fact that Mr. Reda knew he was there to be evaluated by a defense expert for his lawsuit, considering the fact that you explained to him that your evaluation could hurt him, do you find it unreasonable that he was a little bit defensive?

A. He was, in that context, still unusually defensive, more defensive than average.

Q. Give me some examples of what you consider to be inappropriately defensive?

A. Mr. Reda's behavior, evasiveness, assertiveness, bluntness, the -- he interrupted me, he said, "Hold it. Wait just a minute." At one point, when

I brought up his drug useage, for example, he was demanding in a kind of bullying way.

"Well, let me see the evidence for that" was something that he said, and I think those are sort of -- bullying the doctor is unusual. It's something I'm not used to.

Q. Did Mr. Reda ever rise from his seat during your interview of him?

A. Well, to take breaks and so forth.

Q. For no other --

A. No, no.

Q. During --

A. Not in hostility.

Q. In any threatening way?

A. No.

Q. Did he ever threaten you with physical harm in any way?

A. NO.

Q. Did he become overly abusive to you in any way?

A. That's too strong a phrase.

Q. Would you say he was any more hostile or defensive than, say, a person who is irate at a salesman for selling them a lemon car?

A. That's a fair description of his demeanor, yes.

Q. Doctor, you previously stated that you do evaluations, OK you have done evaluations before for lawsuits and so forth.

MR. MORAW: Objection to the term "so forth" as being overly vague.

Q. Well, let me see if I can be a little bit more specific.

A. I'm sure you can.

Q. You have done other evaluations in the context of lawsuits, correct?

A. Correct.

Q. I think you said that you do approximately -- or no, I don't think you ever did, I take that beck.

Approximately how many evaluations per year do you do in the context of a lawsuit?

A. During the last two years, maybe eight per year.

Q. What about prior to the last two years?

A. It would decline in numbers.

Q. So 1989, 1990, you averaged approximately eight evaluations per year done for purposes of a lawsuit?

A. Yes.

Q. Okay. Out of those evaluations, approximately eight per year over the last two years, what percent is done on behalf of the plaintiff and how many are done on behalf of the defendant?

A. Roughly two-thirds defendant and one-third plaintiff.

Q. Do you remember the names of the attorneys, defense attorneys that you have done evaluations for over the last two years?

A. Yeah, I can remember a few. My memory is a little poor on these things, but David Jones from Eastman & Smith in Toledo; Mr. Ahern, A-h-e-r-n, from Manahan, Pietrykowski, Bamman & Delaney, Toledo.

Q. Are both of those defense attorneys?

A. Yes. You're asking for a list of defense attorneys?

Q. Correct,

A. In your neck of the woods.

Q. Meaning Cleveland.

A. In the Cleveland area, Orlando Williams from Akron.

Q. He is a defense attorney?

A. I think he's with Buckingham, Doolittle.

MR. MORAN: I don't know.

Q. Other than Mr. Moran's firm in Cleveland, have you done any other evaluations for firms in Cleveland?

A. Yes.

Q. Gallagher, Sharp, Fulton & Norman?

A. Yes, yes8

Q. You've done evaluations for them. Again, they are a defense firm?

A. Yes.

Q. Any other defense firms that you can recall that you've done examinations for, or excuse me, evaluations?

A. There is a firm -- well, if -- I met the patient in Elyria, but I believe that very well could be Gallagher with a branch office in Elyria. I get confused about these things.

Q. Do you ever do any evaluations for the defense firm of Meyers, Hentemann, Schneider and Rea?

A. Maybe. I don't -- I just -- I don't know.

Q. Do you recall the name of any of the plaintiff's attorneys for whom do you have done evaluations for?

A. Wasserman & Landry.

Q. Where are they?

A. Toledo.

Q. Do you recall the individual attorney for whom you did the evaluation?

A. Both Wasserman and Landry were working on the case. I'm just drawing a blank on firms. With a minute or two I can come up with a few more names.

Q. How would you do that?

A. Go and look at the list.

Q. Go right ahead.

A. In fact, if you would like, I will give you the list.

Q. Oh, that would be fine. Do you have a list of both plaintiff and defense?

A. Yes.

MR. DeROSA: Do you have any objection?

MR. MORAN: No objection.

(A brief recess was had.)

Q. Doctor, you've been kind enough to hand me a copy of what looks like a typed up list with defense attorneys listed, plaintiff's attorneys listed, and major companies listed.

A. Right.

Q. Is that a complete list of all defense attorneys, plaintiff attorneys, major companies that you

have done work for up to the present?

A. No, that would be a complete list as of, say, eight months ago. That's when we drew it up for this kind of purpose.

Q. This was -- this list that you've handed me with these attorneys on there, it was drawn up for what purpose, now?

A. To -- for two separate purposes. One is for this very situation where I'm asked and I just can't remember.

Q. You mean during a deposition when you're asked to give names?

A. Right, right. The other thing is to -- it is part of a one-page leaflet. When somebody calls in and they're interested in what we do, we send that leaflet, and it tells them how to send a case to us and so on, and, also, it includes that,

Q. Okay. Thank you, Doctor. Do you recall when you did your last examination on behalf of a plaintiff in a lawsuit, how long ago that might have been?

A. Last one that I can recall was a firm in a small town in Ohio. That may have been five or six months ago. I'm not sure it's on that list, because the list was done earlier. It had to do with a plaintiff who died

after a large hook, industrial hook fell and hit him on the head, and his estate was involved suing the company. I'm involved now on a couple of bereaved parents who are suing for emotional damages they suffered after their son had died.

Q. Who were the plaintiff's attorney in the bereavement case.

A. I can find out.

Q. Rather than interrupt the proceedings here, when we're done can you provide me with the names of those attorneys?

A. Yes.

Q. Do you recall offhand the name of the attorney from that small town on the death case?

A. No, but once again, we can certainly find it.

Q. Okay, thank you. Have you ever -- these evaluations that you have just been talking about were not the actual treating psychologists for any of these cases?

A. That is generally correct, yes.

Q. Have you ever testified in the context of a lawsuit as a treating psychologist?

A. Yes.

Q. Approximately how many times have you testified as a treating psychologist?

A. Say two or three times. I can remember only one example, and once again, can't remember the name of the lawyer in the case, but say two or three.

Q. Was that individual your patient before the lawyer became involved, or was the lawyer the referring individual for that particular patient?

A. In the -- in the case that I am thinking of, I was first one of the treating psychologists and then became involved legally.

Q. In the lawsuit?

A. Right.

Q. How much do you charge for an evaluation in the content -- that is done in the context of a lawsuit?

A. Well, it's $100 an hour, and a typical examination involves about two hours of face-to-face interviewing, about four hours of records review, about four hours of report writing, and so that -- and perhaps a few tests, and so it comes to about a thousand dollars.

Q. For your complete evaluation?

A. That's right.

Q. And when you go to Cleveland, say, to do an evaluation, you charge for your travel time?

A. Correct.

Q. How much do you charge for your travel time?

A. $100 an hour.

Q. How much do you charge for deposition testimony?

A. It works out to really basically the same fee, but I do it on a half-day basis, $500 per half day.

Q. And you consider how many hours a half a day?

A. I haven't defined it sharply, but a half day typically means from 8:00 until, say, 12:00 or 1:00, and 12:00 to roughly 5:00.

Q. And how much do you charge for your trial testimony, if you actually testify at the trial or your videotape deposition is used at trial?

A. Same rate.

Q. Approximately $100 an hour or $500 a half day, or any part thereof?

A. Yes.

Q. How much do you charge a patient for actual treatment? If a patient were to come to you and say, 'Dr. Layne, I want you to treat me,' how much do you charge that individual?

A. $90 an hour.

Q. Why do you charge more for evaluations per hour than you do to treat a patient?

A. Patient treatment is so much more organized

and routine. By contrast, legal work, that's what I call it, is more disorganized; there's more wasted time, more preparation. To put it differently, on a hourly basis, I'm not sure that I get $90 an hour for legal work because there are these little preparations and so on. I don't have to study real hard before I see a patient. I have to, though, study harder before a deposition, for example.

Q. You have to familiarize yourself with the facts and familiarize yourself with your records and reports that you have generated and the reports and records that were supplied to you by other psychologists that may be in the case; is that correct?

A. Correct.

Q. And before your deposition here today, you, in fact, did that type of review?

A. Correct.

Q. And Mr. Moran was present, correct, for at least part of that. You met with Mr. Moran before your deposition here today?

A. Correct.

Q. Okay. I notice on your board right there that you have some writing, and it's like a chalkboard where you use a water marker -- is that what you call it?

A. Yeah, dry marker.

Q. -- dry marker on them, and that board is situated right opposite your desk, correct?

A. Right.

Q. And those notes or markings pertain to Mr. Reda's case, correct?

A. Correct.

Q. When were those notes made?

A. This morning before Mr. Moran got here.

Q. What was your purpose in making those?

A. To keep those facts in my mind.

Q. Okay. I want you to take a look at that board there, and I want you to go line by line and first read exactly what it says, and then I'll ask you questions on each line.

A. Okay. The first thing you should know is that the numbers that go down the left side of the board are Mr. Reda's age. The numbers in the upper right-hand corner are two important dates that I need to remember, his birth date, April of '59, and then down below it, the date of his examination.

Q. Which is March 8th of 1991.

A. Right.

Q. Okay. Now, the first line on that board says 0, the number zero?

A. Right.

Q. Dash "mom", comma, "limp'.

A. Right. That -- let me give you one other general comment, and that's these notes are from my report. Everything that I'm now going to tell you about is in the report. Okay. "Mom", that reminds me that his mother had a health-related difficulty when she was 19, which she had when Mr. Reda was zero years old, when he was born. He described his mother as therefore being sort of depressed, having some feelings of weakness and having a limp. He grew up with that mother, and I think it had a minor influence on his outlook about life and so on. He grew up with a slighty ill mother, that's what that means.

Q. The second line says "5", dash, "head", dash, "seizures", three dots, "sue", which I presume to be a lawsuit?

A. Correct.

Q. Another three dots and then "12 years old"?

A. Right.

Q. The 5 meaning he was 5 years old?

A. Correct.

Q. And explain what the other words are and what their import to you is.

A. "Head" means head injury. When he was 5

years old he had a head injury. That caused him to have a seizure for which he took Dilantin, His parents sued on his behalf, set up a trust fund for him. His seizures lasted until he was about 12 years old.

Q. And of what import is that to you?

A. Well, shows a preexisting mental health difficulty. Granted, a head injury is a physical injury, but it has psychological implications. The first is it is interesting that one of his MMPI profiles actually is somewhat consistent with brain damage.

Q. Which MMPI profile?

A. The one that is referred to as a 3-9, and that would be --

Q. .Well, is that the MMPI that you administered is on March 8th, or is that one of the MMPI's *that* were administered by Dr. Lahner?

A. That would be Lahner's MMPI.

Q. Administered on which date?

A. November, November of '88.

Q. That would be the first MMPI that was administered by Dr. Lahner?

A. Correct.

Q. Okay. Now, you say that that particular MMPI indicates what?

A. A minor possibility of organic Brain damage.

Q. Now, when you say "organic brain damage", what are you referring to?

A. Neurological damage, damage to the brain, physical damage.

Q. Physical damage to the actual brain tissues --

A. Correct.

Q. -- is what you're referring to.

A. Right,

Q. And what on the MMPI at least indicates to you that there is a possibility of minor organic brain damage?

A. It is the elevations on the profile. When I say "elevations", I mean the highest points on the graph. His highest points on his graph are 9 and -- scale No. 9 and then scale No. 3. All you have to do is go to books on that kind of profile, books that I cite in my report, and those books will bring up the possibility of organic brain damage as a possibility.

Q. Okay.

A. I went on to quote -- drawing your attention to page 8, at the very top -- perhaps I should start with the sentence on the bottom of page 7, quote, (reading:)

"Absence of depression or anxiety, but hostility is frequently present... organicity needs to be ruled out." So that would be a quote by MMPI expert LaChar, L-a-C-h-a-r, on that profile.

Q. Doctor, are you diagnosing Mr. Reda as having organic brain damage?

A. No.

Q. Are you indicating that organic brain damage affects him psychologically in any way?

A. I don't think so. I don't think that it does. It is interesting that he had a severe -- what sounds like a severe head injury back when he was 5, and now he generates that particular profile. It is of interest, but, if he has neurological damage, it's so subtle that it is hardly worth discussing.

Q. Okay. In other words, it's of no significance to you as a psychologist?

A. It's *of* little -- I mean, it is *of* significance -- I wouldn't have written it on my board or in my report -- but I don't think it's his fundamental problem. It's not a good way to capture his real problem.

Q. You cannot diagnose him as having organic brain damage; is that correct?

A. I think that would be excessive on my part,

yes,

Q. You cannot make that diagnosis, yes or no?

A. I'm qualified to make that diagnosis --

Q. NO, but you --

A. I am not making a diagnosis about him, correct, and it's not in my report.

Q. Okay. Is there other explanations for having an elevated profile on scales 3 and 9?

A. Yes, and those explanations are more credible, more likely, yes.

Q. What are the other explanations for having elevated profiles on the 3 and 9 scales?

A. They are in my report, but they are the -- a person with a long-term history of impulsiveness; mild hostility; poor impluse control; a kind of manipulative style; high energy; liveliness; high sociability but superficial sociability, gets along with a lot of people, kind of a back-slapping Good Time Charlie; someone who by contrast does not think very deeply about his emotions would generally report that he was not anxious, that he is not depressed, that life is really doing just fine. That's really what the 9-3 profile says.

Q. What would be the cause, or is there a cause for the profile which you just described?

A. Yes. It is consistent with what's called a histrionic personality, somebody who -- in a sense, the colloquial word, hysterical, histrionic applies here, lively, energetic, superficial, kind of a chatty, breezy style, episodes of upset which also seem superficial, but they come and go, are relatively easily dealt with by the person, so at any rate, to get back to your question, consistent with histrionic personality traits.

Q. Is the elevated 3 and 9 scales consistent or indicative of any other type of -- or could it be indicative of any other type of disorder, behavior, personality type?

A. It could be called a minor kind of manic-depressive problem called cyclothymia, meaning manic-depressive, but at the low level. Beyond those two problems, manic-depressive illness and histrionic personality disorder, I don't know that it's really compatible with any other.

Q. Okay. The MMPI's that were taker, -- or the second MMPI that was taken by Dr. Lahner and by yourself, do they also show the same elevations?

A. No, the profile varies in minor ways, so -- let me kind of refresh my memory a little bit here. The profile varies in minor ways, so he never technically got

a 9-3 again, but he got other scales that are fairly compatible with a 9-3.

Q. Is it a correct statement, then, that the only MMPI profile that shows a true 3-9 profile would be "the MMPI administered by Dr. Lahner in November of 1988?

A. Correct.

Q. And that would have been administered before she actually started to treat Mr. Reda?

A. I think so.

Q. The two MMPI's that were subsequently given to Mr. Reda, one by Dr. Lahner in February of 1990 and by yourself in March of 1990 were both administered after the completion of Dr. Lahner's treatment; is that correct?

A. I think so.

Q. Would you say that Dr. Lahner's treatment in any way accounts for the fact that the two later MMPI's do not show a true 3-9 profile?

A. They may, they may. His subsequent two profiles, his last two profiles are slightly lower; that is to say more healthy than his first profile.

Q. Is it a fair statement to say, then, that Dr. Lahner's treatment could have helped Mr. Reda?

A. Yes, yes.

Q. Okay. The MMPI that was given by yourself in

March of 1991 was given approximately one year after Mr. Reda completed all treatment; is that correct?

A. Yes, apparently so.

Q. Does it differ significantly from the MMPI that Dr. Lahner gave in February of 1990?

A. The two -- those two profiles are roughly the same. Actually, all three profiles are roughly the same, but -- so, yeah. My profile resembles her profile of February of '90, yes.

Q. Dr. Lahner's MMPI profile of February '90 and your profile of March 1991, from a diagnostic standpoint, are similar?

A. Yes, yes, and both are similar to the earlier profile, too,

Q. But the earlier profile in November of '88 is diagnostically dissimilar, am I correct?

A. It is slightly more pathological, slightly. There's a mild improvement in this guy's personality over time, but a mild one.

Q. He never had a severe problem to begin with, did he?

A. Correct.

Q. Okay. Going back to your board over here, the third line reads "17", dash, "carts", and arrow

pointing to the right, "back", an arrow pointing to the right, "tutor".

A. Right.

Q. Tell me what that means.

A. Well, he told me he was pushing some shopping carts and he felt some pain in his back. He was taken out of school for that pain and actually had to get a tutor during that time that he missed school.

Q. Why is that of significance to you?

A. Histrionic personality disorders have a history of health problems or apparent health problems that lead them to withdraw from work, and this is an example of that.

Q. Now, you said health problems or apparent health problems,

A. Right. Histrionic people tend to be slightly overly sensitive to physical health.

Q. But the health problems that histrionic personalities suffer from, are they real or imagined?

A. There is an exaggeration of physical health problems.

Q. Okay. The third line of your chart there, "17", "carts", "back", "tutor", do you consider that to be a exageration of health problems on the part of Mr. Reda?

A. I'm not sure. I didn't get any records of that injury.

Q. All right. Well, what did Mr. Reda tell you about that injury?

A. That at age 17 he was pushing some shopping carts when he felt a ping in his back. That resulted in him missing months of schooling.

Q. Was he hospitalized?

A. I believe that he was.

Q. Do you know how long he was hospitalized?

A. I'm not sure, but I recall him saying that he was put in traction for a couple of months.

Q. Do you know what the diagnosis was? Did he tell you what the diagnosis was of the injury that he sustained when he was 17 years old pushing those carts?

A. I don't believe that he told me what the diagnosis was,

Q. Wouldn't that be important to you, Doctor, to know what the diagnosis was?

A. Yes, that would have been helpful.

Q. That would tell you whether or not it was a real or imagined injury, would it not?

A. Well, it would help; it would help.

Q. Well, if the diagnosis came up that -- well,

let me put it this way: If all the medical doctors could find nothing physically wrong with Mr. Reda's back, that would tend to lead you believe that it was an imagined health problem, would it not?

A. It would -- if I understand your question correctly, it would increase the probability.

Q. That it was an imagined health problem?

A. If the doctors had no diagnosis, correct, if they could find nothing wrong with his back, It is obviously true that if he spent months in traction, the physicians felt that he had a real injury or problem or something.

Q. A real injury. So the injury that Mr. Reda sustained when he was 17 years old, is, therefore, not an imagined health problem?

A. No, no, and I didn't say that it was.

Q. It's a real health problem?

A. Well, the -- I don't know. All I know is that in the histories of histrionic people, there are numerous entries in medical records of illnesses that remove the person from work. They can be legitimate illnesses, but the person's experience grows that health problems enable you to withdraw from work, real or imagined.

Q. The history that you took from Mr. Reda, did you ask him what his work history was with his current employer, the Ohio Department of Natural Resources, concerning absences?

A. I don't recall that being a problem in the -- in the first couple of years, no. In fact, I recall him telling Psychologist Lahner that he was doing fine at work, everything was okay, he was being praised for his work, but -- so no, no evidence that at first he had any problem with absenteeism.

Q. Is that consistent or inconsistent with the histrionic personality disorder?

A. It's -- a severe histrionic personality disorder would have more time off ,from work. They would not have a perfect employment record. I don't think he's severe, but --

Q. Well, is his work history with his current employer, Ohio Department of Natural Resources, consistent with a mild histrionic personality disorder?

A. Well, yes, in certain ways, I think it is.

Q. In which ways?

A. We are back to the problem of what he called double-dipping.

MR. DeROSA: Okay. So I don't have to

interrupt, just have a continuing objection to any reference to his employment problems, so on and so forth, and the record will reflect your objection to my objection.

MR. MORAN: Right.

Q. Okay. Go ahead, Doctor,

A. Well, a histrionic personality disorder is a manipulative personality, likes to get out of work however he can, and the business of billing two companies simultaneously is, therefore, consistent with that manipulative style. It's just another way to extract advantage.

Q. Are you aware of any awards, citations, commendations that Mr. Reda received from his employer, the Ohio Department of Natural Resources?

A. No.

Q. Would that make a difference to you in assessing his personality?

A. Well, yes, any new information would be interesting.

Q. If Mr. Reda would have received over the course of his employment with the Ohio Department of Natural Resources several commendations, letters of commendation, awards for the performance of his work for

the Ohio Department of Natural Resources, would that change your opinion of Mr. Reda's personality disorder?

A. No, that one set of facts really wouldn't change the weight of opinion here.

Q. Why not?

A. Well, histrionics are manipulative, they like to get out of work. They are also attention seekers. I would -- I would not be surprised if he had done something relatively bold and dashing, something a little flashy, and had been complimented for that, because that attention-getting quality is also one of the characteristics. But you can get attention by doing a lot of spectacular good things or by being sick.

Q. What if it's nothing flashy? What if it's just doing your job well, if he received awards for simply doing his job well?

MR. MORAN: Objection,

Q. Would that change your opinion at all?

A. No. Remember, I've diagnosed this guy as being normal. I've said that he has characteristics of a histrionic personality, so I've never said that he had a severe problem or even a mild problem, He just has this tendency.

Q. So you're not diagnosing him with a

histrionic personality disorder?

A. That's right.

Q. What you are doing is you are saying that as of the time you evaluated Mr. Reda, he was essentially a normal individual?

A. Exactly.

Q. That could help speed this along greatly.

A. That's right.

Q. All right. Doctor, rather than continuing to go through line by line and have you explain all the things on your board there, I'm going to read what's on there, and you tell me if I'm reading it wrong, and then if you don't say anything, it's okay to assume that I'm reading ,it correctly, all right.

The fourth line says "18", underlined; dash, "drugs", three dots, "22", underlined. The next line says, "18", underlined, "Youngstown", capital "F" in parenthesis, comma, in parenthesis, question mark, cornma, "OU", in parenthesis, "back", four more dots, and then "22".

The next line says "24", dash, "work"; next line says "29", dash, "duck", and there's a hyphen, "gravel", comma, "friendly", comma, "radio", dash, "don't rush", comma, "summons", comma, "no hospital", comma,

"photos", comma, "ER", two dashes, "no anxiety", comma, "returned", exclamation point, comma, "no lever", comma, "returned", period. Next line reads "narc", and the final line reads "32 exam". Did I read that correctly?

A. Exactly.

Q. Doctor, how many patients do you treat in a week, actually treat? I don't want to include in there evaluations, but treat?

A. About 15.

Q. Per week?

A. Correct.

Q. Your week consists of five days, five work days?

A. That's right.

Q. So to speak. And your work days are approximately how long?

A. About ten hours.

Q. Approximately ten hours. And how long on average do you treat each one of your patients?

A. An hour.

Q. One hour. So you spend approximately 15 hours per week out of your work week --

A. That's right.

Q. -- treating patients.

A. Correct.

Q. There's another 35 hours in your work week.

A. Right.

Q. What do you spend, on average, those other 35 hours doing?

A. Teaching at the University of Toledo.

Q. And how many hours do you spend a week doing that?

A. About 10; writing for articles or a book or other things.

Q. And how many hours do you spend a week doing that?

A. Say 5 or so.

Q. Are you including in that writing writing of reports for evaluations?

A. No, these are other things, publications.

Q. These are *just* writings *for* publication in various journals and papers and so forth?

A. Right, right. Administrative work here takes up another 8 hours a week; public appearances on TV or radio or speeches is another 2 hours a week. The legal evaluations, this kind of thing, takes up hours a week, say 6 or 7 hours a week. And now I don't know how many hours I've got left over.

Q. Well, any other activities associated with your profession that you engage in other than what you've already described for us?

A. I can't think of any others.

(Discussion was had off the record.]

Q. Any other professional activities that you can think of?

A. No, that's about it.

Q. All right. We have your 15 hours per week treating of patients; 10 hours per week teaching; 5 hours per week writing; 8 hours of administrative work; 2 hours of public appearances, and 6 to 7 hours of evaluations. Now that may or may not add up to 50 hours but --

A. Close enough.

Q. *Any* other professional activities that you can think of?

A. I can't think of any others.

MR. MORAN: For the record, it adds up to 48 hours.

Q. We'll let you have lunch a couple times a week.

A. Yeah, right, right.

Q. Doctor, you're licensed in the State of Ohio; is that correct?

A. Yes.

Q. And what specifically is your license for?

A. Psychology.

Q. Psychology. Do you hold a license in any other state?

A. I had a license in Mississippi. When I moved from Mississippi, of course, it lapsed after years.

Q. Have you ever had any license in this state or any other state refused to you?

A. No.

Q. Did you ever have any license revoked?

A. No.

Q. Have you ever had any license suspended?

A. No.

Q. Have you ever been sued for malpractice?

A. No.

Q. For anything?

A. No.

Q. For mal or misfeasance?

A. No.

Q. Doctor, have you ever diagnosed anyone as having post-traumatic stress disorder?

A. Yes.

Q. On how many occasions have you made that

diagnosis?

A. Perhaps 10 to 20.

Q. 10 or 20?

A. 10 to 20. I would say 20 times is a good estimate.

Q. Are those in people you have evaluated for others, or are those in your own patients that you are treating, or is it a combination of both?

A. Both.

Q. It is a combination of both?

A. Yes.

Q. Out of the people that you have diagnosed with post-traumatic stress disorder in a legal setting, meaning where you've just evaluated them, what percentage does that constitute of all those who you have evaluated claiming to have post-traumatic stress disorder?

A, Let ne make sure I got the question, Out of all the people I've evaluated who claim to have post-traumatic stress, what percentage of the time do I agree with them, sort of?

Q. Or of their treating doctors, that's a much better way to put the question.

A. About two-thirds of the time.

Q. So approximately two-thirds of the time you

agree that the person has post-traumatic stress disorder?

A. That's right. In fact, I can explain and it might be worthwhile. Often, when the person says, "I've got post-traumatic stress", they, in fact, do, and my --

Q. Now, when you say "the person", are you saying the person individually or are you referring to that person's doctor who has made the diagnosis?

A. Yes, the doctor, yes.

Q. So the person doesn't come to you and say, "I have post-traumatic stress disorder"?

A. No, no, no. The -- often I agree. Sometimes the dispute, if a dispute does develop, it develops because the person claims that the disorder lingers forever, and the research on the topic suggests that it does not, and so often my -- the way in which I may add to the litigation is that I will discover that they have gotten over their post-traumatic stress disorder in a year or in six months or in a year and a half, so that becomes, a lot of tines, my input into the case or my unique contribution to the case.

Q. In this particular case, meaning Mr. Reda's case, do you agree that he had post-traumatic stress disorder at one time and has now recovered, or are you saying that he has never had post-traumatic stress

disorder?

A. I'm saying he's never had it,

Q. He's never had it, okay, So he would fall into the category of the one-third of the people who you disagree with?

A. Right.

Q. Okay. Let me just back up a little bit, Doctor. We talked about the number of evaluations you do for lawsuits. Do you also do evaluations for Workers' Compensation claims?

A. Yes.

Q. The information that you gave us earlier as to the numbers and so forth, I believe you said you did approximately eight evaluations per year for lawsuits?

A, Correct.

Q. Are you including Workers' Compensation claims in those numbers? or --

A. No, that's additional.

Q. All right. How many Workers' Compensation evaluations do you do in a year?

A. It varies, but on the average, I would say about six per year.

Q. Six per year?

A. Yeah.

Q. And the six per year that you do do, are those on behalf of the employer or on behalf of the claimant?

A. Most are on behalf of the employer.

Q. More than 95 percent of the time, you examine or evaluate on behalf of the employer?

A. Say 90 percent of the time.

Q. 90 percent of the time. Are the charges that you make for those Workers' Comp evaluations, are they the same that you would charge for an evaluation for a lawsuit?

A. Yes.

Q. Now post-traumatic stress disorder is a very real illness, disease, or condition?

A. *Yes*, it is.

Q. Is it an illness?

A. It is a mental illness,

Q. And people get post-traumatic stress disorder from a variety of causes?

A. Correct.

Q. And all those causes do not involve actual personal injury to the person?

A. They need not.

Q. All right. In fact, you, yourself, have

diagnosed people with post-traumatic stress disorder who have suffered no injury at all?

A. Exactly.

Q. So the severity of the injury sitting alone by itself is not determinative of whether a person suffers from post-traumatic stress disorder?

A. That's correct.

MR. DeROSA: Off the record.

(Discussion was had off the record.)

Q. Back on the record. Doctor, you used the DSM-III -- or the DSM-III-R?

A. Yes, the III-R.

Q. The DSM-III-R, that's pretty much the bible for, I guess, psychologists?

A. It is.

Q. And that's used for diagnosing disorders and illnesses and others maladies --

A. Yes.

Q. -- by a psychiatrist or psychologist?

A. Correct.

Q. Tell me what the DSM-III-R defines a traumatic event as?

A. It gives examples under the --

Q. Let me preface that. The DSM-III-R specifies

the criteria for diagnosing post-traumatic disstress orders; correct?

A. That's correct.

Q. And it ascribes the number 309.89 to it.

A. I don't -- I don't know.

Q. Okay. Within the diagnostic criteria set forth in DSM-III-R is a definition of a traumatic event, correct?

A. Within the criteria, yes,

Q. And what does the DSM-III-R describe or define a traumatic event as for purposes of post-traumatic stress disorder?

A. That which is outside the range of usual human experience and that would be markedly distressing to anyone, and then it goes on to give examples of the kinds of things that they're talking about.

Q. You took a verbal history from Mr. Reda?

A. Yes, yes.

Q. You took a history of the shooting incident, correct?

A. That's right.

Q. You also had some records to review?

A. Yes.

Q. Some of those records also contained a

history of the shooting of Mr, Reda, correct?

A. Correct.

Q. You also had the Geauga County Hospital records which described some injuries that Mr. Reda sustained in the shooting, correct?

A. Yes.

Q. The history that you obtained during your evaluation of a person is extremely important, is it not?

A. It is.

Q. And the history includes not only what the persons tells you, but other information that you're able to obtain from other sources?

A. Correct.

Q. And in your opinion, what's the best source of a history, is it the person just sitting there telling you things, or is there another source that is even better than the person who you're evaluating?

A. The best source of history, long-term history are the documents, I think.

Q. What documents would you consider important in the history?

A. Oh, dear. I mean, there's so many, school records, hospitals records, physician records, notes made by the patient himself, letters, employment records, and

so on.

Q. Those types of records are important to you independent of the person's recollection or recitation of his own history?

A. Yes.

Q. As a general rule, do you find those more accurate than the person's recitation?

A. Yes, in general, the documents are more valuable, more accurate.

Q. Would you consider those types of documents as the best source of history when you evaluate a person?

A. Yes.

Q. Would you consider documents an important source of information concerning a traumatic event if you're trying to evaluate a person for post-traumatic stress disorder?

A. Yes.

Q. Would you consider it important to have as much information in documentary form about Mr. Reda's shooting incident as you could possibly have?

A. Yes.

Q. What documentary evidence did you have -- do you have concerning the actual shooting incident of Mr. Reda?

A. His statements to emergency room personnel on the day of the shooting.

Q. Do you have any other documentary evidence?

A. The -- the emergency document itself and not just his -- Mr. Reda's descriptions of what happened --

Q. What I'm referring to is regardless of what the document contains, do you have any other documents, hard paper copy of documents describing the actual shooting of Mr. Reda?

A. No, I don't think so.

Q. Have you ever been supplied with any police reports?

A. No.

Q. Any police photographs?

A. No.

Q. Have you talked to anybody else concerning the shooting incident other than Mr. Reda?

A. No.

Q. Have you read Mr. Reda's deposition?

A. No.

Q. Have you read his wife's deposition?

A. No.

Q. Have you read Frank DuGuid's deposition?

A. No.

Q. Have you read the deposition of the witness, Mr. Stack?

A, No.

Q. Is it safe to say, then, that the only source of information that you received for the shooting incident itself was Mr. Reda and the Geauga County Hospital records?

A. Yes. The -- I should interject that I believe that Lahner's first report describes the shooting incident, and maybe her second, and that's of some value.

Q. Based upon your personal interview with Mr. Reda and your review of the documents that you have from Geauga Hospital and Dr. Lahner, tell me what you know of the shooting incident?

A. Mr. Reda was in the woods. He saw a couple of guys shooting, or heard them shooting, walked up somewhat cautiously and looked through some bushes to see what was going on. Now, let me interject at this point that all this is in my report, and I'm simply trying to remember what I put in my report.

Q. Doctor, if you want to look at your record, go ahead. This is not an exercise in memory evaluation here, so if you want to use your record, go right ahead.

A. Okay. So to pick up where I left off, he

stepped out from behind the bush and started to approach the two hunters or shooters. He saw one of them suddenly turm and point his gun at him, meaning Mr. Reda. Reda's immediate thought was that this guy's going to shoot me, I better duck, so as he dropped to one knee,

He heard a single shot. He saw the ground in front of him sort of vibrate or kick up; he knew that these were shot pellets hitting the ground in front of him, He then felt the debris as it spattered on his glasses and body, and he thought that it was dirt and rocks that had been kicked up by the shotgun blast.

The thought ran through his mind to shoot back, and he saw the guy immediately point his gun away from him, meaning Mr. Reda, so Mr. Reda assumed that it was safe to approach them, and he did so as he felt the rush of adrenalin.

Q. Okay. Doctor, let me stop you right there. Based upon your knowledge of the history of the shooting incident itself, would that incident qualify as a traumatic event as defined by the DSM-III-R?

A. It's borderline as a traumatic event.

Q. All right. Let me ask you some specific questions, then. The shooting, or Mr. DuGuid turning and pointing a shotgun at Mr. Reda and pulling the trigger and

having the gun go off while pointed and Mr. Reda is definitely an event, correct?

A. It is.

Q. Wouldn't you agree that it is an event outside the range of usual human experience?

A. Yes.

Q. Okay. Would you agree that that event would be markedly distressing to almost anyone?

A. Here's where we get into that gray area. In hindsight, obviously, we now know that Mr. Reda was hit with pellets that he had to pull out of his skin.

Q. Doctor, I don't want to go into hindsight.

A. Okay.

Q. Let me ask you this question: If you are standing in a room, outside, wherever, somebody turns points a gun at you and fires, whether you're hit OH not, would that not be a markedly distressing event?

A. It depends on the way I perceive it. For example --

Q. Doctor, let me ask you a few questions. Are you a hunter?

A. No.

Q- Are you a shooter; in other words, do you target shoot with guns at all?

A. I have target shot.
Q. Have you shot shotguns before?
A, Yes.
Q. 12-gauge, 16-gauge, or 20-gauge?
A. It was a long, long time ago, and very rarely.
Q. They make a lot of noise.
A. Yes.
Q. Okay. And they're quite large, shotguns are quite large.
A. Yes.
Q. And have you, yourself, ever been shot?
A. No.
Q. Have you yourself ever been shot at?
A. I've been hit with a BB gun.
Q. Which is a small BB gun that you pump up with air?
A. Right.
Q. And it leaves a little red nark on you and that's about it?
A. That's right.
Q. Have you ever been shot with anything more substantial than a BB gun?
A. NO.

Q. And you haven't been shot at by anything more substantial than a BB gun?

A. That's right.

Q. Okay. Have you ever served in the military?

A. No.

Q. It's safe to say, then, that you've never served in any type of armed conflict?

A. Correct.

Q. Have you ever been a police officer?

A. No.

Q. Rave you ever served in any type of law enforcement capacity?

A. NO.

Q. Have you ever witnessed a shooting?

A. No.

Q. Have you ever treated police officers who have beer. involved in a shooting?

A. Yes.

Q. All. right. And how many police officers have you treated who have been involved in a shooting? Now, let me define for you by what I mean by involved in a shooting -- either have been shot themselves, have been shot at themselves, have shot other people, or shot at other people.

A. I can recall two police officers and one civilian who came to me specifically because they were shot,

Q. Were they shot or shot at?

A. They were shot.

Q. And were you the treating psychologist?

A. Yes.

Q. In each of those three instances?

A. Yes.

Q. And do you recall what type of weapon each of those three individuals were shot with?

A. In the case of one person, it was a handgun. In the case of another it was a handgun. In the case of the third, I believe it was a shotgun.

Q. The third that was a shotgun, was that the civilian or one of the police officers?

A. That was one of the police officers.

Q. Do you know from what distance he was shot with the shotgun?

A. Say 20 or 30 yards, something like that,

Q. 20 or 30 yards. Do you know what type of injuries he sustained?

A. I don't think that he was hit. I believe that he was -- this is the vaguest of my three

recollections.

Q. Your best --

A. I just -- I don't recall the shotgun incident. I recall very well the two handgun incidents.

Q. All right.

A. But I don't --

Q- The police officer that was either shot or shot at by the shotgun, what did he come to you for?

A. As I recall -- I just don't remember.

Q. Do you remember if you made a diagnosis for him?

A. That I don't recall either. Let me think about it for a minute. If I could think out loud for a moment, the civilian was shot in the neck in a drug-ridden neighborhood. It was a random drive-by shooting.

The police officer that I'm thinking about was in a squad car, had a buddy, was attacked by someone after they pulled him for a traffic violation or something, and as I -- that may have been the shotgun incident. It could have been a handgun incident, but what happened was the person basically shot at them, they ran back and got in their car. The assailant then came up to the window of the squad car -- the assailant shot, either with a shotgun or a handgun, shot one of the two police

officers and killed him. My guy then ran back to the car, got in the car, and there was another blast from either the shotgun or the handgun, The police officer had been hit -- that's why I think it was a handgun, he had been hit. He then got onto the floorboard of the car and basically waited to die. He thought that the assailant was going to come up to the car and blast him. The thing that I'm having trouble with is tearing that apart from the third. I'm not sure if that was a shotgun or not.

Q. So at this point you don't have a clear enough recollection to testify with any certainty about it?

A. That's right.

Q. Doctor, would you agree with me that to the general popluation, having a shotgun aimed at you from approximately 30 to 35 yards and then fired at you would be a markedly distressing event -- it says to almost anyone, that's what the DSM-III-R says, that it would be markedly distressing to almost anyone.

A. My answer again is that it's a borderline situation, borderline because -- and I don't mean to seem -- if I could just explain for a second.

Q. Go right ahead.

A. The criteria goes on to say, for example, a

serious threat to one's life or physical integrity, the sudden destruction of one's home or commmunity. NOW, the key here is that when they say "markedly distressing", by golly, they mean markedly distressing. They mean that in the person's mind, he's thinking I'm going to die or I'm going to be ripped up physically, I'm going to lose my arm, very much like that policeman I was telling you about on the floorboard of the car saying I've got somebody that's going to come up to the window any minute now and he's going to blow me away. That is the genesis of post-traumatic stress.

I say Mr. Reda never entertained that thought. He never had more than a minor -- well, than a startle over this. I don't mean the word "minor". He was startled, but he never thought he was going to die; he never thought he was going to be hurt. When he was shot, he didn't ever! know he was shot.

Q. Well, whether or not he knew he was *shot* bears no relation or has no importance other than whet he perceived when Mr. DuGuid turned and shot the weapon. That occurs after the actual event.

A. Say that again, I'm sorry.

Q. His perception of whether he is actually shot or not, whether he was actually injured --

A. Yes.

Q. -- comes into play later, after the event is over, correct?

A. Yes, yes. It's relevant only in that at the moment of the shooting he didn't know that he had even been hit.

Q. Well, what did mr. Reda tell you was going through his head when he saw Mr. DuGuid turn towards him with the shotgun?

A. His first thought was I better duck. His second perception was that he saw the ground kind of kick up in front of him. He felt what he thought was gravel kind of sprayed on him.

Q. What did Mr. Reda do when he saw Mr. DuGuid point that shotgun at him?

A. Lowered himself to one knee.

Q. What else did he do? Take a look at your report if you need to.

A. Okay. Well, he thought to himself, The guy's going to shoot, I better duck. He dropped to one knee, heard the shot, saw the ground, felt the debris, thought about shooting back, but --

Q. Thought about shooting back. Did he do anything in preparation of shooting back?

A. He gave me no indication that he did.

Q. You've dealt with police officers before, correct?

A. Right.

Q. Do you know the basic parameters of when they can draw a weapon or when they are permitted to shoot back?

A. Well, in self-defense, I assume they are allowed to shoot back.

Q. Well, if a police officer draws his gun and aims it at an individual, would you consider that police officer as being in fear of his life?

A. It would --

Q. It would be a good indication that he was in fear of his life, wouldn't it?

A. That's a possibility, or in fear of -- well, I -- I mean, you can draw your gun to --

Q. Let me be more --

A. I don't know.

Q. Let me be more specific. If Mr. Reda would have drawn his gun in response to Mr. DuGuid turning and aiming that shotgun at him, would that be an indication to you that Mr. Reda was in fear of his life?

A. That he at least ought to defend himself,

yes, you could put it that way.

Q. Okay. Well, would you say that Mr. Reda thought himself to be -- or at least his life to be seriously threatened if he drew his gun?

A. It is quite possible that for an instant, yes.

Q. Okay. All right.

A. This may help also. You may notice a minor technicality in my report, and that is on page 11, I list the criteria for post-traumatic stress. Under the criteria in A, I have got a question mark if you can see that, and that means, you know, maybe. So I don't want to --

Q. You're not ruling it out, in other words?

A. No, I'm not,

Q. Okay. It very well could have been what the DSM-III-R defines as traumatic event, the shooting of Mr. Reda?

A. Yeah, it could be. His actions afterwards suggest that it is not but --

Q. What you're telling me now is, though, that the shooting of Mr. Reda could have been within the definition of the DSM-III-R traumatic event?

A. Criteria in A, that's right, could have been.

Q. Criteria in A, okay.

A. That's right.

Q. Now, you're aware, obviously, that Dr. Lahner diagnosed Mr. Reda with post-traumatic stress disorder?

A. Yes.

Q. And you, yourself, say he does not have post-traumatic stress disorder and never did, correct?

A. Right.

Q. And I have learned here today that you are not saying he doesn't have any other disorder either.

A. That's fair.

Q. Okay. Do you believe Dr. Lahner's diagnosis is wrong when she says that he suffered from post-traumatic stress disorder?

A. That's right.

Q. Is it your testimony that there's no way that she could be right and you could be wrong in your opinion?

A. It's reasonable aegree of psychological certainty.

Q. Well, in other words -- well, what do you define as reasonable degree of psychological certainty?

A. A little over 50 percent sure.

Q. So you're 51 percent sure that you're right?

A. At least.

Q. Okay. And she's at least 51 percent sure that she's right?

A. That's right.

Q. Okay. So that means that both of you could be 49 percent wrong -- or there's a 49 percent change that either one of you could be wrong?

A. Well, I'm -- I'm talking the -- I've been talking about the legal criteria.

Q. Well, that's wnat we have tu *go* by.

A. Right.

Q. Okay. Now, we're in a legal setting here so we have to use legal criteria.

A. Sure, perfectly legitimate.

Q. So in the legal criteria, there's a chance that either of you could be 49 percent wrong?

A. There is a 49 percent chance that -- there is at most a 49 percent chance that I'm wrong is a good way to put it, yeah.

Q. Okay. You certainly are not always correct in your diagnosis, or when you express an opinion you certainly are not always correct?

A. That's right.

Q. And you certainly don't always think that you're correct?

A. Right.

Q. You will admit that there are occasions when you have been wrong?

A. Right.

Q. Now, on your footnote 12 on page 19 of your report, you talk about inter-judge reliability?

A. Yes.

Q. And it applies to the MMPI?

A. To the DSM.

Q. Or to the DSM-III-R.

A. Yeah.

Q. What does inter-judge reliability mean or refer to?

A. I mention it twice, under severity of stressors and under severity of ills. Do you want a general definition for both of those?

A. Give me a general definition of the term "inter-judge reliability".

A. It is the consistency of second opinions. That's a good way to look at it. When a doctor says that someone has a problem or has a problem of a certain severity, what is the probability that a second doctor will agree with the first doctor.

Q. Okay. So what that footnote indicates is the

percent of times that the second doctor will agree with the first doctor's diagnosis?

A. Well, it's not given in terms of percentages. It's given in terms of co-relation coefficients.

Q. Well, looking at footnote 12 on page 19, there's two inter-judge reliabilities given by yourself.

A. Uh-huh.

Q. One is for severity of stressors or physical problems.

A. The first one is severity of stressors.

Q. Okay.

A. And the second is severity of ills.

Q. Okay. Now, when it says inter-judge reliabilities are good for physical problems, severity of stressors --

A. Well, it doesn't say for physical problems.

Q. For severity of stressors?

A. Yes.

Q. Inter-judge reliability for severity of stressors are good .59-.75.

A. Yes.

Q. What does that mean?

A. That the -- if two doctors rate a given individual as having a certain level of stress in his

life, then another doctor will agree to a eo-relation level of between .59 and .75.

Q. For us that are not conversant in those terms or statiticians, put that in terms that are more readily understandable.

A. The first thing to realize is that an inter-judge reliability is a severity and how bad off is the person. Again, what it says, that when -- let's look at it a different way.

If we walk 100 people, 100 patients, past two mental health experts, each one of those two rates the severity of the stressors in the lives of each patient, then you hope that their numbers come out co-related; that is, if Dr. A rates everybody -- rates a certain person as having a lot of stressors in his life, Dr. B will also say there's a lot of stressors. As that agreement gets higher and higher, the co-relation begins to approach 1.0. If there's absolutely no co-relation at all, if Dr. A and Dr. B have no co-relation at all, the co-relation then would be zero. So we're talking about the scale of relationship between 0 and 1, and the co-relations are 1.

Q. So when foot note 12 says the inter-judge reliability for severity of stressors is between .59 and .75, using your example of those 100 people, somewhere

between 59 and 75 of those people the doctors will agree on as to the severity of the stressors.

A. I'm afraid it's not that easy. These eo-relations are not percentages, but are --

Q. Well, maybe we could look at it a different way, and maybe there is no way. Maybe you don't have an answer for this question, but the DSM-III-R is used universally by psychologists, psychiatrists, correct?

A. Yes.

Q. If you have two psychologists, two doctors, whatever, examine the same person, what does the literature tell you as to those doctors coming up with the same diagnosis? What percentage of the time will that occur?

A. All right. We're not talking about the diagnostic label and not severity, which is what we've just been talking about, The answer to that question is found in the research literature that's reported in DSM-III, not DSM-III-R. The eo-relation coefficient varies as a function of different illnesses, and I hate to make this more complicated than it needs to be.

Q. Let's narrow it down more. For post-traumatic stress disorder, what does the literature tell you concerning the percentage of times that two

doctors will diagnose the same person the same way?

A. As I recall, the co-relations are pretty good, say .7, .8, somewhere around there. Percentage agreement just would be guessing, because most of these things are reported in terms of co-relation coefficient and not percentage agreement, but I'm guessing that physicians and psychologists will agree say three out of four times, maybe four out of five,

Q. Okay. Based upon your best estimate, then, somewhere between 20 and 25 percent of the time, doctors have a difference of opinion when examining the same individual --

A. Right.

Q. -- for the same condition?

A. Right. In terms of post-traumatic stress, yes.

Q. In terms of post-traumatic stress, okay.

(Discussion was had off the record.)

Q. Now, you administered the MMPI to Mr. Reda?

A. Correct.

Q. What is the MMPI designed to measure?

A. A broad range of mental illnesses.

Q. Is it designed to measure or to detect post-traumatic stress disorder?

A. While it wasn't designed to do that, it certainly can do that.

Q. By itself?

A. Yes.

Q. Independent of any other psychological testing or procedures?

A. Yes. The test can reflect post-traumatic stress. It would be irresponsible to use only the test, but nevertheless, the test can certainly reliably detect it.

Q. What about ruling out post-traumatic stress disorder? Can the MMPf by itself rule out the existence of post-traumatic stress disorder?

A. No -- no test should be used in isolation from other data.

Q. In other words, the MMPI is only one of thea tools that a psychologist should use in making a diagnosis in either ruling in or ruling out post-traumatic stress disorder?

A. Right. It is one tool, a good one, a very good one, but a tool nonetheless.

Q. Okay. Are there any tests specifically designed for post-traumatic stress disorder?

A. There are -- I'm not sure, but generally,

there probably is a checklist or something somewhere that claims to measure post-traumatic stress. I'd argue -- anticipate that such a test would not be well-researched, it may have the label post-traumatic stress inventory, but it won't be a very well-researched test.

Q. Why is that?

A. Well, there are tests for lots of things. You know, just like in medicine, you can get a medical test that will tell you whether you're pregnant or what your horoscope is going to be tomorrow or whatever. That doesn't make them good, and I know of no widely used, widely accepted post-traumatic stress test.

Q. In other words, there isn't a test that has been used widely enough to get the statistical research to confirm its validity?

A. That's right, other than the MMPI and the Millon.

Q. Can a person fake his answer5 on the MMPI; in other words, can he give a dishonest test without the person administering it knowing?

A. It's unlikely, because the MMPI's got several validity scales, and so it becomes very difficult to beat the tests.

Q. There are scales built right into it that

detect when a person is either lying or faking or exaggerating?

A. *Yes.* Even further, if the person doesn't understand the test, if they can't read, if they just mark randomly by mistake, the scales will pick that up.

Q. The MMPI that you gave to Mr. Reda contained those scales of validity?

A. Right.

Q. What are the three scales of validity?

A. The so-called L scaled.

Q. Which is the lie scale.

A. The F scale and the K scale.

Q. The F scale is the fake scale?

A. Yes, some call it the fake bad scale, yes.

Q. And the K scale is the so-called fake good scale?

A. Yeah, defensiveness scale,

Q. Defensiveness scale. How did Mr. Reda score on those three validity scales on the MMPI scale that you administered?

A. He scored so defensively that his test profile was invalid.

Q. What do you mean, his test profile was invalid?

A. He tried to put himself in such a good light psychologically.

Q. Does that mean he tried to tell you that he had no psychological problems?

A. That's right, and he tried that so hard that he invalidated the test.

Q. What scale or scales are you basing that on?

A. His K --

Q. His K?

A. Right.

Q. Okay. Now, when you say his profile is invalid, does that mean you can't use it for diagnostic purposes?

A. Yes, it -- other than the validity scales.

Q. In other words, you can comment on the fact that he's a guy that's really putting his best foot forward?

A. His profile itself, though --

Q. Scales 1 through 10?

A. Exactly, and then for ancillary scales and type response, ego strength and the so-called max scale, those then become pretty unreliable.

Q. And you, yourself, would not use them as -- or for diagnostic purposes?

A. I would not use -- he was -- it's qualified, because he was barely invalid. He barely crossed the line, so I wouldn't --

Q. Isn't that like being a little bit pregnant, though?

A. In a way it is. You've got to interpret -- in this case, the only difference is that it's a continuum. There certainly is a continuum on the K scale. There is a line,

Q. But you, yourself, because of the validity scales showing an invalid profile, you, yourself, would not feel comfortable using the MMPI that you administer for diagnostic purposes?

A. Other than the validity scales.

Q. Other than the validity scales?

A. Right.

Q. Would you use the 1 through 10 scales generated by Mr. Reda in your test for comparison with other standardized MMPI profiles?

A. Yes, *yes*, you can. You can take a group of people who have generated a profile, an MMPI profile, plot it, then plot his invalid profile, and then the question is does this invalid profile resemble this other profile.

Q. Isn't that a little bit like comparing apples

and oranges, though? You have valid profiles that you are comparing to an invalid profile trying to make a comparison,

A. Well, if we're -- for example, we're probably talking here about page 13 of my report.

Q. Correct.

A. If I could direct your attention to that, on the left side, page 13 -- now I'm looking at the MMPI profile -- there are three profiles plotted. Looking at validity scales which are to the far left under the word "male", all of those profiles are invalid technically. Reda's profile is invalid because his K scale is elevated.

The post-traumatic's profiles are also invalid, but for exactly the opposites reasons: Their F scale is invalid, and so what we have here is two groups of post-traumatic stress victims, both basically crying for help, basically saying I'm really nuts; in fact, overdoing it in that direction, Man, I am really hurting, nobody's listening to me, I'm trying to tell you I'm really hurting, That's with the typical post-traumatic stress disorder victim. Reda, he says nothing's wrong with me, I've never had a problem, I never get anxious, I never become depressed. So that contrast is a stark, bold contrast.

Q. Go ahead, are you finished?

A. But they're all invalid in the sense that the validity scales all tell you something about the person, about the person's style.

Q. On page 13, those two comparison profiles that you use, Vanderplug's, I guess his name is?

A. Uh-huh.

Q. And others?

A. Right.

Q. Do you know what type of traumatic events those particular victims were exposed to?

A. Give me a minute. In both cases, these were combat-related post-traumatic stress disorders victims, people in wartime.

Q. Where do you get that information from?

A. Footnote number 13, the titles of the articles that report these two profiles are there under footnote 13.

Q. Footnote 13 tells me Psychometric Profile of Post-Traumatic Stress Disorders Anxious and Healthy Viet Narn Veterans,

A. Correct.

Q. Or Keying Psychosocial Responses?

A. Yes,

Q. Nowhere does that say that they were combat related?

A. Viet Nam veterans, if you look at the articles, I think what you'll find is that these are veterans of heavy combat.

Q. Okay. The second, Vanderplug, is Re-evaluation of the Use of MMPI in the Assessment of Combat-Related Post-Traumatic Stress Disorders. Do you know whether the victims in either one of those two studies were actually shot, or just experienced traumatic events in the course of combat?

A. I believe that they generally experienced traumatic events, which includes being shot or witnessing horrors.

Q. Do you know when the individuals in those two particular studies were tested in relation to the traumatic events?

A. The tine, I believe, varied fairly widely, anywhere from months to years afterwards.

Q. Do you know if any of those individuals whose profiles are plotted in either one of those two studies had any prior psychiatric problems or treatment before the so-called traumatic event?

A. They may or may not have.

Q. Do you know?

A. No, I don't recall the articles that well.

Q. Do you know if they had received any treatment after the traumatic events, but before the testing, which generated the two studies?

A. I -- while I don't recall that, I recall the more important point, which at that moment they were diagnosed as having a problem.

Q. Okay. But you don't know whether or not they received any treatment before they actually took the MMPI that generated those two studies?

A. Right, right. All I know is treatment or no treatment, they did have that diagnosis.

Q. Okay. Do a person's MMPI results differ if he takes it before treatment and after treatment?

A. Well, one would certainly hope so, particularly if the treatment was effective.

Q. So an MMPI that was given before an individual with post-traumatic stress disorder entered treatment would differ from his MMPI that he was given after the treatment had been completed?

A. Well, it depends on whether or not the treatment worked.

Q. Assuming that the treatment was successful.

A. Right.

Q. That scenario would generate two different MMPI profiles?

A. Yes, I suspect that to be true.

Q. Okay. Would the MMPI profile change during the course of treatment; in other words, if you administer, say, four MMPI's to an individual, one before treatment commenced, one when he was one-third of the way through, one when he was two-thirds of the way through, and another one when he had completed his treatment, would you expect to see a difference in the MMPI profiles at each step along the way?

A. Yes, if the treatment were the correct kind of treatment, and if the --

Q. And assuming it is, you know, the correct treatment.

A. Yes.

Q. And also assuming that the treatment --

A. That it works.

Q. That it works, yeah. Thank you. Okay. Was Mr. Reda cooperative during your -- well, I guess you did not administer the MMPI, but to your knowledge, was he cooperative when he took the MMPI and the Millon test?

A. Yes.

Q. Was he cooperative during your interview with him?

A. Reasonably so,

Q. To your knowledge, did he omit answering any questions, any large number of questions in either the MMPI or the Millon?

A. I don't believe that he omitted any.

Q. Now, you -- I've been mentioning the Millon test. You chose to give him the Millon test?

A. Yes.

Q. What is the Millon test intended to measure?

A. Two domains of a person's psychological make-up, and they are first, his long-standing personality problems or health, and then secondly, his psychological illness or health.

Q. Why did you choose to give him the Millon test?

A. Primarily because the research on the Millon is extremely promising research, It tends to show the test to be accurate.

Q. When you say "promising", that leads me to believe that it has not been final -- judgment has not been passed upon it?

A. That was a poor choice of words. It has been

validated. It is a good test. It's not perfect, but neither is an x-ray or a CAT scan, but it's a very good, solid, validated test.

Q. Is the Millon appropriate for an individual to take once they have completed their treatment?

A. Sure.

Q. I reason that I ask that is because in the report that accompanies the Millon graph, it states in the very first paragraph -- and I'll give you an opportunity to get that so you can follow along with me --

MR. MORAN: What page are *you* on, Joe?

MR. DeROSA: It's numbered page 2 of the Millon report. It's the page right after the Millon graph here.

THE WITNESS: Do you by chance have mine, or is that yours?

MR. DeROSA: This is mine. You should have yours.

Q. All right. It states, MCMI-II, which is the Millon Clinical Multiaxle Inventory II, correct?

A. Uh-huh.

Q. MCMI-II reports are normed, which means what?

A. That means that the --

Q. We are comparing Mr. Reda with patients who

are in the early phases of assessment or psychotherapy because of emotional discomfort or associated difficulties, correct?

A. Yes.

Q. So you're -- I read that correctly. Let me just go back and read the whole sentence so the record's clear.

A. Okay.

Q. The sentence reads, "MCMI-II reports are normed on patients who are in the early phases of assessment or psychotherapy because of emotional discomfort or social difficulties." I read that correctly this time?

A. Yes.

Q. All right. That then says that Mr. Reda was being compared to patients who were in the early phases of assessment or psychotherapy?

A. That's right.

Q. Is that appropriate?

A. Yes, I believe that it is.

Q. All right. Mr. Reda was through with his treatment?

A. Right.

Q. He had -- he was way past early assessment,

was he not?

A. Correct,

Q. And he was completely done with his psychotherapy, was he not?

A. Yes.

Q. Why, then, do you feel it appropriate to compare him with individuals who were in the early phases of assessment or psychotherapy?

A. Well, the -- we need a normative group for any test. They are making it clear that this normative group has this set of characteristics. At a technical. level, I can now -- we can hold up his profile and say that, for example, compared with people who are just entering treatment, Reda is relatively high on his histrionic trends. He is healthy otherwise, and that's informative. It's informative that even next to a group of people who are seeking treatment for problems, even next to that relatively pathological group, he's pretty high on histrionic personality trends.

Q. Isn't it true, though, Doctor, that the Millon test, the results of that test, including his histrionic scale, is distorted or very likely could be distorted because he does not fit the norm of the patients?

A. No, I don't agree with that because the -- when you talk about fitting in with the norms, I don't think that the testing experts want to be very strict about that interpretation. I mean, he has been in treatment.

Q. Let me read the next sentence to you. It says, (reading:) 'Respondents who do not fit this normative population or who have inappropriately taken the MCMI-II for non-clinical purposes may have distorted reports." Clearly, you have to agree that Mr. Reda does not fit the normative population?

A. Well, I think that he does, and I say that because while he is not in the initial phases of treatment, he had received treatment, and --

Q. He had completed treatment.

A. Right, And that's close enough.

Q. Are we getting into another one of your gray areas?

A. This time, I don't believe that we are.

Q. No?

A. I don't think any professional would disagree with me about the administration of this test to him. Furthermore, the top of page 11, you'll notice a -- a statement right up at the top in the middle of the page,

it says valid report. This report goes on --

Q. Is there anywhere in that report were there's room to indicate that Mr. Reda had already finished his psychotherapy and did not fit the normative population for the test?

A. No.

Q. All right. Do you know whether or not that information would change that valid report to an invalid report?

A. It wouldn't change it,

Q. How do you know that?

A. Because the validity scales on the Millon are very much like the validity scales on the MMPI.

Q. So that valid report has nothing to do with the fact that Mr. Reda may have or may *not* have fit into the normative population?

A. Well, I think it does. If a person were way outside the normative population, then the validity scales would go awry, validity scales would point out that this person's not behaving correctly towards the test.

Q. Well, Doctor, do you make it your practice to give tests to patients who do not fit the normative population of that test?

A. I believe that he does fit the normative

population. Once again, the intent of the author of this computer program is to say that if a person is not claiming a psychological problem, if he's just curious about what his psychological make-up is and he appears to be perfectly normal and does not want any treatment and is not claiming that he has any mental illness, watch out.

Q. Well, it also says if he's not in the early stages or early phase of assessment and psychotherapy watch out.

A. Respondents who do not fit this normative population, who do not fit it -- again, what we're quibbling about here is does he fit the population of people who are in the early phases of assessment or psychotherapy because of emotional discomfort or social difficulties. He -- I mean, I think he fits those statements reasonably well. He is -- I thought he was claiming emotional and mental illness. If he is not, if he's not -- at the time of my examination, if he was really saying to me, Doctor, there's nothing wrong with me, I don't claim any mental illness at all, okay. I don't think he was doing that.

Q. Well, Doctor, you knew at the time that you evaluated him and administered this test that Dr. Lahner had diagnosed him as being in remission --

A. Correct.

Q. -- for the post-traumatic stress disorder?

A. Right.

Q. Remission meaning that he had no active symptoms.

A. Right.

Q. Correct?

A. Right, yes.

Q. You also knew that he had completed his treatment over a year before you administered the test?

A. *Yes,*

Q. Now, you're telling me, as a lay person sitting here, that his completing treatment a year prior does not equate with early phases of assessment or psychotherapy?

A. Yeah. It does with me, in that --

Q. Well, what would you -- what length of time would you consider inappropriate in order to administer the Millon test, what period of time from completion of treatment? If Mr. Reda has been finished with his treatment and has been in remission for two years, would you still think it appropriate to administer the Millon test?

A. Let me give two answers to that question:

Answer number one, Reda has gone for two years and has shown no emotional problems whatsoever, no psychological problems. He says I'm happy.

Q. You're taking this as a theoretical?

A. Theoretically. He is reporting no emotional problems whatsoever; he is saying to the world, I am well, I have healed, I have no emotional problem, don't claim I do; I also am not claiming that down deep, down in some recess, I don't even have a problem. In that case, this extremity would be inappropriate were there no problem.

Scenario number two, that he is now five years after treatment, and he is saying I still have that problem, that gunshot has hurt me emotionally; I still think I have a problem; I need to be measured for this problem; this problem is somehow lingering; subconsciously, back in some recess, whatever, at whatever level, I think I still have that problem; I need to be assesse'd for that; I'm worried I'm sick; I'm worried I'm mentally ill. In that case, the gunshot could have occurred 30 years age, it still would be appropriate to say Okay, let's assess you for this. He would then be in a stage of assessment. They would be asking -- posing the question, is there something wrong with me. And again, I thought that was his statement, I thought he's arguing

there's something wrong with him now. I mean, if he's not --

Q. You're then saying that when the authors of this computer program warn against administering to people who are not in early phases of assessment or psychotherapy, you can ignore that under the conditions that you just testified to?

A. No. I believe that if I were talking with these authors and I said, Hey, I got a guy that claims he's mentally ill because of an event that occurred 40 years ago, what do you think, how would you describe that, I think what they would say is, well --

Q. Well, Doctor, I don't want you to get into what they may say or may do.

A. Okay. That's the way I read their statement.

Q. Well, your testimony is that even though a person is a year past the finish of their active psychotherapy, it's appropriate to administer the Millon test.

A. Yes.

Q. Okay.

A. I have one other comment, and that is the computer printout is extremely conservative. They don't want to get sued. It's a very conservative report. They

want to put in a lot of disclaimers.

Q. Mow, Doctor, we have been talking about this Millon and everything, and we go back to your earlier statement, whether the MMPI is valid or invalid, whether the Millon is valid or invalid. Your bottom line was that at the time you diagnosed -- or excuse me, evaluated Mr. Reda, he was normal?

A. *Yes.*

Q. Okay. So he had no personality disorder, in your opinion?

A. **Correct.**

Q. Okay.

A. As I said in the report, he has symptoms of or signs of, tendencies towards, but no, no mental illness,

Q. To your knowledge, did Mr. Reda have any psychiatric **treatment** prior to **the** shooting **incident?**

A. None that I am aware of.

Q. Did he have any diagnosed psychiatric disorder prior to the shooting?

A. None diagnosed, that I'm aware of.

Q. Okay. Can you give the names of some books or authors who you consider to be authoritative on post-traumatic stress disorder?

A. Some are listed in my report, the studies by Vanderplug and by others. DSM-III-R is the authority on post-traumatic stress disorder.

Q. Are there any other books or authors that you consider authoritative or who you would consult with for post-traumatic stress disorder?

A. There again, I can read them from my report, but the -- as I recall, when it comes to the curability of post-traumatic stress disorder, there is a number of authors I list in this report.

Q. What about as far as diagnosing the disorder, what authors or books do *you* consider to be authoritative?

A. DSM-III-R is the authoritative reference.

Q. What about other authors or books that you consider to be authoritative, although they might not be as authoritative as the DSM-III-R.

A. I car! think of none.

Q. You can't think of any?

A. That's right.

Q. Doctor, to your knowledge, Mr. Reda was actually struck by some of the steel pellets from the shotgun blast; is that right?

A. That's correct.

Q. Did you ever view any pictures that were

taken after the shooting incident, that were taken by the police?

A. No.

Q. Do you know how many pellets Mr. Reda was shot or struck by?

A. The report, as I recall, indicated roughly five or so.

Q. Do you know where he was struck at?

A. The thigh.

Q. Anyplace else, and again, refer to your records and reports if you need to.

A. The chest area, but again, they apparently hit his vest; maybe his glasses.

Q. Anyplace else that you, in reviewing your reports and records, can determine?

A. In the emergency room report, he complained of soreness in his scalp, left hand, and his right thigh. The exam indicated the scalp was normal; that his chest was normal; that he had an abrasion on his left index finger. He had some abrasions on his right thigh, and a puncture wound, so we're looking at a finger, thigh, and possible scalp.

Q. Okay. Doctor, did you ask Mr. Reda during your interview of him to describe what his job as a game

protector involved, what it was like?

A. In a general way, I believe that I did.

Q. Is a game protector the type of job that is self-motivated?

A. Well, I don't know. I guess -- I just don't know.

Q. Well, is it the type of job were there's somebody constantly looking over your shoulder telling you what to do, how to do, and when to do something?

A. No, I believe he said he spent a good deal of time alone in the job.

Q. So it's the type of job that one decides oneself when they are going to do something, how they are going to do it?

A. I don't know.

Q. You don't know. Do you know whether or not Mr. Reda interacted well. with the public in his job prior to the shooting?

A. He apparently told Psychologist Lahner that he had a good reputation in the commmunity and so on. His profile suggests that he would be a nice, sort of cordial person superficially.

Q. Was -- to your knowledge, was Mr. Reda conscientious about his job prior to the shooting?

A. He indicated that to the psychologist.

Q. Do you have any information to dispute that?

A* Well --

Q. Again, I'm limiting my question to prior --

A. Right.

Q. -- to the shooting.

A. His work record, in general, prior to the shooting, is -- has some rough areas, but on that job, I just don't know.

Q. You say his work record has some rough edges?

A. Right.

Q. What are the rough edges?

A. He quit three colleges in a row right around the same time.

Q. Well, that's not work history, that's educational history. We'll get into that later. You're grouping that together?

A. Yes, those are work.

Q. Limiting it strictly to employment,

A. Okay. I know of no errors or no poor functioning in his work prior to the shooting.

Q. Do you have any information to indicate that Mr. Reda was not a good employee prior to the shooting?

A. I just don't know.

Q. Okay. Would you like to know that?

A, Sure.

Q. Would it have any bearing on your diagnosis or your opinion as to whether or not Mr. Reda had post-traumatic stress disorder?

A. Whether or not he was a good employee before the shooting, I don't see how that would be relevant.

Q. Okay.

A. No.

Q. Now, I want to go to your report --

A. Okay.

Q. -- and I want to go over it with you. In the history section on the first page, you list the documents or sources of information. You say, "I studied two sources of information, his statements to me, and roughly 40 pages of documents," and then you list the documents.

A. Uh-huh.

Q. You've already stated that those are the only documents you've ever seen.

A. Yes.

Q. Okay. We go down to the next subheading entitled Physical Complaints, Illegal Drugs. Is that section based solely upon your interview with Mr. Reda?

A. Let's look. You're now asking me where I got

this information?

Q. Correct. Just under the heading Physical Complaints.

A. Illegal drugs, which is on page 1 and part of page 2. The best way to answer that question is look at the footnotes, the end note cited in that section.

Q. Why don't you do that and tell me all the sources of information that you used in order to report physical complaints ana illegal drugs.

A. Okay. Footnote 3 is in that section, and it cites Psychologist Lahner's letter of 7/31/89; footnote 4 is from Psychologist Lahner's handwritten notes; footnote 5 is also from Lahner's handwritten notes. The footnote also indicates that I showed Mr. Reda those handwritten notes, went over them and said -- basically deciphered them in front of them, and he agreed that my interpretation of her notes was accurate.

Q. Any other sources that you used in preparing the section entitled Physical Complaints and Illegal Drugs?

A. The other source would be the interview.

Q. With Mr. Reda?

A. Right.

Q. Now, you say here his mother had a stroke

when she was 19, and by the time he was born she suffered fatigue and depression.

A. Yes.

Q. And that has footnote 3, and footnote 3 says you got that information from Dr. Lahner's report of 7-31-89?

A. Right.

Q. I want you to get Dr. Lahner's report of 7-31-89, and tell me where you find in Dr. Lahner's report that Mr. Reda's mother had a stroke at age 19 and by the time Mr. Reda was born she suffered fatigue and depression.

A. Okay. I'm quoting now from -- from her letter.

Q. What page, please?

A. Page 1, middle of the page. Mother was a full-time homemaker, and then moving on -- that's not relevant. Moving along, his mother at times suffered from periods of depression.

Q. Doctor, to me that doesn't sound like "By the time he was born she suffered fatigue and depression".

A. Right. These citations aren't necessarily ones that cover the entire sentence. Notice that, for example, in this case, the footnote is on the word

'depression", and that's what it says in this letter.

Q. So you have added material from sources other than those that are footnoted?

A. As I just mentioned, this entire section was drawn from the footnoted sources, and also from my interview.

Q. Well, where did you get the information that she avoided, meaning Mr. Reda's mother, avoided working outside of the home?

A. That was probably from what Mr. Reda told me.

Q. Probably, again, your notes would have been helpful, would they not, in answering that question?

A. Well, no, I really don't think so, since the notes were basically dictated in the report.

Q. Well, do you know whether Mr. Reda's mother ever worked outside of the home?

A. Be said that she did not, Lahner says that she was a full-time homemaker, and I guess that's --

Q. For what period of time is it your understanding that Mr. Reda's mother never worked out of the home?

A. He told me that she was a housewife and never worked anywhere else.

Q. From the time he was born up until the time

that you interviewed him?

A. I believe so, yes.

Q. Now, is the fact that you believed that his mother was a housewife and suffered fatigue and depression important to you in determining whether or not Mr. Reda suffered -- or did not suffer from post-traumatic stress disorder?

A. It is important in a minor way in any discussion of histrionic personality features. It is important that a child grows up with a mother who has a constant low level physical malady.

Q. And in your second paragraph there, you state that at age 5 Mr. Reda experienced his first injury in a car accident, He suffered a severe head injury. After surgery, he began having seizures, so he was placed on the sedative Dilantin.

A. Yes.

Q. Where did you get the information that he had surgery after that accident?

A. Let me check. I believe he told me that.

Q. Okay. That would have been in your notes as well, then?

A. I mean, not necessarily. I -- I may have remembered that and dictated that in.

Q. So the fact that he had surgery was either something that you remembered or something that you wrote down in your notes?

A. Correct.

Q. Okay. You go on to say that his seizures and Dilantin lasted for seven years until he was age 12.

A. Uh-huh.

Q. Where did you get that information?

A. The seizures are noted in Lahner's handwritten notes.

Q. Where did you get the information that his Dilantin lasted €or 7 years?

A. He told me that. That is also in Lahner's notes, the word "Dilantin".

Q. Is there anywhere in Dr. Lahner's note that his Dilantin treatment lasted for seven years?

A. I don't believe so. I think that's something he told me.

Q. So again, the fact he was on Dilantin for seven years is something that you either remembered or wrote down in those notes?

A. Yes. This is a complicated way of saying that's what he told me during the interview.

Q. Okay. Going to the next paragraph, you state

that he learned that injuries can be profitable. His parents sued for his injury and won a fair amount of money, and they set up a trust fund for Mr. Reda. Do you know how the accident happened?

A. No.

Q. Do you find it objectional that a person who is injured through the negligence of somebody else recover damages to compensate them for their injuries?

A. Not at all.

Q. You think that's appropriate, do you not?

A. Yes.

Q. The amount of money that Mr. Reda received was how much?

A. I don't know.

Q. Well, you put down there a fair amount of money.

A. I think that Mr. Reda indicated to me at the time of our interview that it was a fair amount of money and that he wasn't sure how much it was.

Q. Does the amount of money become important to you?

A. It's relevant,

Q. In what way?

A. Well, if a person won a lot of money, it

would be more noteworthy than if he won a little money.

Q. We're based on his -- we're not talking about winning money here.

A. Okay, being compensated for.

Q. What do you consider a lot of money that would be important to you?

A. I can't say. Gee --

Q. Well, Doctor, you obviously had a reason for putting down the fact that his parents sued for his injury and won a fair amount of money, because that was important to you.

A. *Yes.*

Q. All right. And you said it was important to you for a reason.

A. Uh-huh.

Q. All right. Now, what was that reason that it was important to you?

A. Because as a child, he, therefore, learned that illnesses can be profitable. You can -- by virtue of having an injury, you can recover money, that is relevant. He had experience with lawsuits.

Q. Does the amount of money make a difference as to how well that child learns that lesson?

A. It makes a minor difference. Obviously, if

the child was compensated in the amount of $10 million, that would make more of an impression than if he were compensated with $100, for example,

Q. Does the fact that the minor has no access to the money make a difference as to his learning that lesson about injuries being profitable?

A. No access to the money, I don't think it makes much difference. I think the child is -- again, we're in hypotheticals now. In this particular case, he told me that they set up a trust fund for him, My guess is that as a child, learning that a trust fund is set up for you is good news, and it's understandable. A child can understand that.

Q. What does a child learn? I mean, why does that make a difference *that* a child learns that you can recover Compensation if somebody negligently injures you?

A. You learn about the nature of lawsuits; you learn that that is a legal way that you can go about getting yourself compensated for something that happens. It's an educational experience.

Q. Is it *a* bad educational experience?

A. NO.

Q. Does it lead to problems later on in life, that simple fact standing by itself?

A. NO, no,

Q. Is it indicative of any behavioral problems that a child will have in the future?

A. It is one tiny influence on his histrionic traits. In my opinion, it made a difference.

Q. It made a difference?

A. Yes,

Q. Okay. If a person receives a lot of money, he would -- would it be more plausible that that would contribute to a histrionic personality as opposed to a person who receives a small amount of money?

A. That influence is minor. You know, I mentioned the extremes, 10 million versus 100.

Q. That would make some difference, but the --

A. Obtaining the compensation is the major factor.

Q. Now, *you say* in the next paragraph, more complaints of injuries followed.

A. Yes.

Q. Why did you choose to insert the word "complaints" in that sentence?

A. Because he goes on to say that when he was pushing the carts, he felt a pain in his back.

Q. Did you not believe that he injured himself

when he was pushing those carts when he was 17 years old?

A. I just don't know, don't have enough information, but it is clear that he complained of pain,

Q. If, in fact, Mr. Reda did severely injure himself in that incident, would you be willing to take out that word "complains"?

A. No, he would still be complaining of pain. If he were hit by a truck and his spine were broken in three places, he would still be complaining of pain.

Q. Your use of the word "complain" does not indicate your disbelief in his history or his telling you that he injured himself, in other words?

A. That's correct. I'm just trying to be as objective as possible.

Q. When you evaluated or came to your opinions on Mr. Reda and his tendencies towards histrionic personality, did you assume that Mr. Reda injured himself severely at age 17?

A. No, I did not make that assumption.

Q. What assumption did you make concerning that incident when Mr. Reda was 17 years old?

A. That the -- he had made complaints of pain, that he had been treated for it. That's about as far as I could go. I mean, he didn't know what his diagnosis was

either, so we're left with that objective set of facts. Had I gone on to say, By golly, he was physically injured, then, of course, I'm vulnerable to the question, Well, how do you know that, so I leave it at the objective level. This is, in fact, what he told me.

Q. Does it make a difference in your opinion that he had histrionic personality tendencies as to whether he only complained of being hurt as opposed to actually being hurt?

A. It would make a difference. If he exaggerated back then, then that increases the severity of his histrionic problems. If he didn't exaggerate, if it were just a clear injury, then once again, much like the lawsuit, while it's not a symptom of a histrionic personality problem, it certainly does predispose it, because you see, he's now got one more experience with illness.

(Discussion was haa off the record.)

Q. Doctor, the next paragraph on page 2 of your report states that a few years after Mr. Reda was taken off Dilantin, he began indulging himself. He abused illegal substances?

A. Yes.

Q. Are you using the word "abused" as that term

is defined in DSM-III-R? That is a personal --

A. It is a non-technical use of that term.

Q. Non-technical use. He, in fact, according to the DSM-III-R, never abused any illegal substance, correct?

A. Right.

Q. Why did you choose to use the word "abuse" in that particular sentence knowing full well that it did not fit the criteria of DSM-III-R?

A. Well, I didn't call it a technical term, and throughout the -- this report and Lahner's report, you'll find words that have a technical meaning, but are not used in a technical sense at that moment, so I used it because it's also in the dictionary.

Q. Well, what is your definition of "abuse" as you used it in your report?

A. It means that he used illegal substances in order to get high as opposed to €or some medicinal purpose or to just quell, say, anxiety. There might be somebody that would say, "I smoked grass because I'm treating my own nervousness". He didn't use these drugs to treat himself for something. He did it to get high.

Q. How many times did he use cocaine?

A. I don't know. I don't believe it was many

times.

Q. How many times did he use marijuana?

A. I don't recall,

Q. How many times did he use speed?

A. I don't recall that either.

Q. The -- there is a difference between casual experimental use of illegal drugs and abuse, is there not?

A. Right.

Q. If a person uses an illegal substance once or maybe a handful of times, would that be abuse or just casual or experimental use according to your definition? Again, I'm not going into the DSM-III-R criteria.

A. Give me the question again.

Q. If a person uses an illegal substance once up to five or six times, say, according to the definition of the word "abuse" as you used it in your report, is that abuse, or is that casual use or experimentation?

A. In terms of the meaning of the word as I used it, that would be abuse. It is not the technical use of that term. By "abuse", I meant non-medicinal use.

Q. So according to your definition, anybody who used an illegal drug for non-medicinal purposes was a drug abuser?

A, According to my use of that word, that's

right.

Q. Okay. And that directly conflicts with the definition of "abuse" as contained in DSM-III-R, correct?

A. Directly conflicts is too strong a word. The DSM-I11 as a technical meaning is a little more severe.

Q. Okay. DSM-III-R says for abuse, "A maladaptive pattern of psychoactive substance use indicated by at least one of the following: Continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance", correct?

A. Right.

Q. Any indication that Mr. Reda fit drug abuse ~ ~ d tehart particular criteria?

A. Well, it -- I mean, it is striking to me that his three experiences in college in exactly the same time frame --

Q. Doctor, do you have any direct evidence that Mr. Reda fit the criteria of drug abuse as I just read to you from DSM-III-R, that particular criteria?

A. If you don't mind, would you read it again, please?

Q. "A maladaptive pattern of psychoactive

substance was indicated by at least one of following: Continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance."

A. No, I don't think so.

Q. DSM-III-R goes on to say, 'Recurrent use in situations in which use is physically hazardous." Does Mr. Reda fit that criteria?

A. I don't think so.

Q. Okay. Doctor, we know that you do not believe that Mr. Reda suffered post-traumatic stress disorder.

A. Right.

Q. Is that because he did not fit the DSM-III-R criteria?

A. That's right.

Q. The DSM-III-R criteria for post-traumatic stress disorder, we've already gone through the traumatic event, the person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, i.e., serious threat to one's life or physical integrity, so on and so forth.

A. Okay.

Q. And I believe we finally agreed that the shooting experience could be a traumatic event for Mr. Reda; is that correct?

A. That's right.

Q. The next prong of the DSM-III-R criteria, identified at paragraph B states, "The traumatic event is persistently reexperienced in at least one of the following ways: (1) Recurrent and intrusive distressing recollections of the events," and then it says, "In young children, repetitive play in which themes or aspects of the trauma are expressed."

Do you have any indication in any of your records, reports, or other information that Mr. Reda complained of recurrent *and* intrusive distressing recollections of the event?

A. No.

Q. All right. Draw your attention to Dr. Lahner's July 31st, 1989, report.

A. All right.

Q. Page 2, "He stated he was having frequent and disturbing recollections of his injuries which he could not always control, and which, at times, persisted even though he was trying to concentrate on other things."

A. I explored that with him and believe that what he really meant by that --

Q. Well, Doctor, that's not my question.

A. Okay.

Q. Dr. Lahner reports that Mr. Reda had recurrent and intrusive and distressing recollections of the events, correct?

A. Well, she reported frequent and disturbing recollections. The word "intrusive" is not in there.

Q. Would you agree that that would fit the first criteria in paragraph B of the DSM-III-R?

A. Well, because it leaves out the word "intrusive", I would say no, that it does not. Intrusive is important.

Q. What does intrusive mean?

A. It's the contrast. It's important for the person to remember something over and over. It's even -- to go farther, a person can remember something over and over frequently and be disturbed by it, but intrusive means that the events come in -- that the memories come in on the person and that they -- they intrude, they come in without the person's deciding to think about the event.

Q. Wasn't that indicated when Mr. Reda told Dr. Lahner that these thoughts persisted even though he tried

to concentrate on other things? He was trying to get rid of them. To me that sounds pretty intrusive.

A. There's no doubt that Lahner believed that --

Q. Well, that's what Mr. Reda reported to her.

A. Right.

Q. Okay. Obviously, somebody's thoughts are not objectively measured, so one has to rely upon the reports of the patient, correct?

A. Right.

Q. So Dr. Lahner, in her report, indicates that Mr. Reda was complaining of that.

A. Right, that is in the report.

Q. Okay. So Mr. Reda then has reports of the first subpart of paragraph B.

A. Well, in my -- I came to a different conclusion.

Q. Well, that's not my question to you, Doctor.

A. Okay, sorry.

Q. Mr. Reda made that complaint.

A. That is indicated in the report, yes.

Q. Okay. The second subpart of paragraph B says, 'Recurrent distressing dreams of the event."

A. *Yes.*

Q. Mr. Reda complained to you of dreams.

A. Correct.

Q. All right. And you have in parenthesis in your report, "He does not dream of the event but instead has vague, abstract dreams about violence."

A. Yes.

Q. Did you ever read Mr. Reda's deposition?

A. NO.

Q. Do you know what he said in his deposition about his dreams?

A. No.

Q. Mr. Reda, to your knowledge, never complained concerning the third paragraph, "Sudden acting or feeling as if the traumatic event were recurring"?

A. No, sir.

Q. Okay. The fourth criteria in the DSM-III-R is, "Intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma."

A. Yes.

Q. Did Mr. Reda complain to you of that at all?

A. No, and really exhibited exactly the opposite.

Q. And that's, according to your report, his continuation of work in dangerous occupations?

A. That's in my report. It goes much farther than that, of course, kept returning to the scene and so on.

Q. Okay. Isn't part of post-traumatic stress disorder, at least as far as the police are involved, is that they try to overcompensate in other areas of their job for feelings of either guilt OK inadequacy?

A. Not at all. It is as simple as this: It is not in the criteria. You will not find in this criteria overcompensation, you'll find exactly the opposite, and again, it's, in my opinion, taking DSM-III criteria and claiming that the opposite is tantamount to the criteria.

Q. Well, the DSM-111 criteria indicates that the traumatic event must be reexperienced in only one of the four ways that we just went over, correct?

A. Correct.

Q. And Mr. Reda had reports of at least two, the recurrent and intrusive distressing recollections of the event and recurrent distressing dreams of the event.

A. He did not indicate recurrent distressing dreams of the event to me.

Q. Okay. But he, at least -- well, can we agree that he at least had recurrent and intrusive and distressing recollections of the event as reported by Dr.

Lahner in her notes and in her report?

A. Lahner does report that. I am skeptical of that interpretation of the facts.

Q. Okay. But it is reported.

A. Lahner reports that.

Q. Okay. And your interpretation of her notes is different; is that what you're saying?

A. I examined Mr. Reda, obviously. I asked him about his recollections of the events. He described those events with calm; he described himself as being calm at the time of the event other than the so-called adrenalin rush at the beginning. He functioned calmly at the time. While he remembered the events later, there was no indication that they were intrusive and disturbing. This was just simply thinking about it, he remembers it, so that's my view of his description of himself afterwards.

Q. Did you specifically ask Mr. Reda whether he was having intrusive recollections of the event?

A. Well, I didn't use those words, but I certainly asked him, you know, what are your memories of the event like, yes.

Q. Well, did you ask him what he remembered of the event, or did you ask him whether or not he continued to have recollections of the event over a period of time

afterwards?

A. Yes, I asked him questions like that.

Q. And what did he tell you?

A. That yes, he remembers the event, he thinks about it, yes. To remember an event as an event is not the same thing as having recurrent --

Q. What you're telling me is he never indicated to you that they were distressing and intrusive?

A. Not both.

Q. Is that contained in your report someplace, If the fact that he did not indicate to you that the thoughts were distressing and intrusive?

A. I'll have to look. You're asking me in the report, he is telling me?

Q. Well, that's the only thing we have to go by because you don't have your notes.

a. I would argue that I have a dictated report of my recollections done on the very day that I saw this guy.

Q. Which you're looking at now.

A. That is right.

Q. Okay. And I'm asking you does that report contain anywhere in it that you asked Mr. Reda whether he was having distressing and intrusive recollections of the

traumatic event?

A. Maybe we can simplify this, I went through the list of DSM-III criteria with him. Now, I didn't lay them in front of him and say, Read them and tell me whether they apply to you, but I went through all of those and checked off or attempted to check off those that fit, and as you can tell, what I came away with is a question mark on A, and really nothing else.

Q. What does the question mark on A refer to?

A. That, indeed, the event is unusual, it is distressing. The question is whether it's sufficiently distressing to qualify under A, and I'm saying maybe it is, all right. I don't want to be shot at.

Q. The rest of the criteria, the entire criteria for DSM-III or post-traumatic stress disorder you say Mr. Reda did not experience at all?

A. That's right,

Q. You're not saying that he experienced efforts to avoid activities or situations that arose or arouse recollections of the trauma?

A. Where is that? I may be able to --

Q. That is paragraph C, subpart 2 of the DSM-III-R.

A. Okay. Again, he did not persistently avoid

stimuli associated with the trauma. He did precisely the opposite. He sought stimuli associated with the trauma, mainly a return to the site of the shooting that very night; a return to the site of the shooting two days or three days later; a return to the same line of work; an either return or initiation of narcotics activities involving guns and so on. To say that he avoided stimuli associated with the trauma is to describe the exact opposite set of conditions than what he --

Q. Did Mr. Reda tell you that he avoided approaching hunters or fishermen after this incident because he was afraid of being shot again?

A. I believe that he told me that right after that, he told me that on the day of the shooting he approached two hunters in exactly the same place that he had been shot. This was in the same hour that he told me he went back to his same job; this was in the same hour that he told me that he began to increase his narcotics work; at the same time that he said that he took risks as a narcotics agent, that he went even further than he used to go. He took more risks after the shooting.

Q. Did he say how he approached these individuals after the shooting, these additional individuals?

A. He said he was reprimanded for taking risks.

Q. You indicated that on the same day the shooting happened, at a later time, he approached what you described as two hunters?

A. Yes.

Q. Did he describe for you how he approached them, what his mannerisms were, what his attitude was towards then?

A. Let me check. Yeah, my report says that he approached them without fear.

Q. Is that what he told you, or is that what you interpreted it to mean?

A. I believe that's what he told me.

Q. Is alcohol abuse a -- something that's frequently seen in post-traumatic stress disorder?

A. It is a -- it is less frequent, obviously, than the symptoms themselves, but can be associated with them. It's a minor sign.

Q. But it is -- is it frequently seen in post-traumatic stress disorder, alcohol abuse?

A. Let me say that it is seen. Frequently, probably not.

Q. Now, you note in here that Mr. Reda told you that he had read about post-traumatic stress disorder and

talked with several people about it. He had a knowledge of his symptoms, awareness of which symptoms a person should and should not report in order to make a case for his illness?

A. Right.

Q. Are you suggesting that Mr. Reda is faking the symptoms in what he told Dr. Lahner?

A. It's possible. He is a somewhat manipulative person, and so it is possible that his readings of those symptoms influenced him.

Q. When did he do this reading?

A. I don't know.

Q. When did he talk to these people?

A. The first person he talked with was before he even sought treatment with Psychologist Lahner.

Q. And who did he talk to?

A. Let's check. He told me that a friend who had also been shot suggested that he might seek help, and as I recall, he had a conversation with this fellow or gal, whoever it was, about being shot, what it was like and so on for that other person.

Q. Do you have any evidence that Mr. Reda manufactured his symptoms or --

A. No, there is no strong evidence for that,

Q. You're not saying that Mr. Reda either faked or imagined or dreamt up these symptoms that he described for Dr. Lahner?

A. It's -- I don't believe that he consciously lied about these things, but I do believe that the personality difficulties he's got lead him to exaggerate when it's convenient to do so,

Q. Are you referring to a histrionic tendency?

A, Correct.

Q. Now, the histrionic personality disorder that you say he has a tendency for is described in the DSM-III-R as "Pervasive pattern of excessive emotionality and attention-seeking, beginning by early adulthood" --

a. Yes.

Q. -- "and present in a variety cf contexts, as indicated by at least four of the following."

A. *Yes.*

Q. All right. "Constantly seeks or demands reassurance, approval or praise." Would you say that applies to Mr. Reda?

A. The question mark indicates that it may. I'm just not sure.

Q. What leads you to believe that it may?

A. For example, his risk-taking.

Q. How does that lead you to believe that he constantly seeks or demands reassurance, approval or praise?

A. He may be taking those risks in order to sort of show others that he's brave, that he's meritorious.

Q. What risks is he taking?

A. The risk as the narcotics officer, the ones for which he was eventually reprimanded.

Q. Were those risks taken before or after the shooting incident?

A. After.

Q. Were any of these risks taken before the shooting incident?

A. I don't know. The ones to which I refer were after the shooting incident.

Q. If the only risk-taking that you're referring to occurred after the shooting incident that Mr. Reda was involved in, wouldn't that seem to indicate to you at least that the shooting incident is the precipitating factor in his taking those risks?

A. well, no. I say that because --

Q. Off the record.

(Discussion was had off the record.)

Q. Anything other than the risk-taking that

occurred after the shooting that leads you to believe that Mr. Reda was constantly seeking or demanding reassurance, approval or praise? Anything in his adolescence or earlier adulthood?

A. No, I can't think of anything else.

Q. Okay. Is Mr. Reda inappropriately sexually seductive in appearance or behavior?

A. I didn't mark that one.

MR. MORAM: I thought all those gold chains and everything --

Q. Is Mr. Reda overly concerned with physical attractiveness?

A. A good bit. I've mentioned weight-lifting in there. A histrionic person is constantly striving for a better and better body,

Q. Describe Mr. Reda for me.

A. Large guy, somewhat muscular.

MR. MCRAN: Two of me and you together.

Q. Would you say he's in the category of slim and svelte?

A. No.

Q. Was his hair precisely styled?

A. I don't recall it being precisely styled, no.

Q. Was he fashionably dressed?

A. I don't think so.

Q. Other than his weight-lifting, is there anything else that possibly you point to that is evidence that he's overly concerned about his physical attractiveness?

A. To some people, physical attractiveness means macho-animal.

Q. Well, are you saying that anybody that lifts weights --

A. No.

Q. -- is overly concerned with physical attractiveness?

A. No.

Q. Is that a question mark that you have in front of this, or is that an asterisk or arrow?

A. It is a question mark.

Q. Okay, The next one is Mr. Reda -- or does Mr. Reda express emotion with inappropriate exaggeration; for example, embraces casual acquaintances with excessive ardor, uncontrollable sobbing on minor sentimental occasions or have temper tantrums?

A, Right.

Q. Does that apply to Mr. Reda?

A. I did not mark that one.

Q. And so that means you didn't believe that applied to him?

A. Right.

Q. Okay. Is Mr. Reda uncomfortable in situations which he or she is not the center of attention?

A. I think that's a possibility, hence the question mark.

Q. Okay, What leads you to believe or what -- why did you put a question mark?

A. His style in front of me. He's a dominant forceful, attention-getting kind of personality, as I talked with him.

Q. Have you ever talked to or met Mr. Reda outside of that room in which you interviewed him?

A. No.

Q. Have you ever met him under any other circumstances?

A. No.

Q. Have you talked to anybody that has?

A. No.

Q. Have you asked Mr. Moran what Mr. Reda was like in his deposition?

A. No.

Q. Have you talked to any of his family or

friends or people at work?

A. No.

Q. So you're basing your opinion that he is uncomfortable in situations which he or she is not the center of attention on your two-hour interview with him?

A. That particular criterion, my two-hour interview and my knowledge of his somewhat reckless behavior on the job.

Q. All of which reckless behavior occurred after the shooting, correct?

A. Right.

Q. The next -- does Mr. Reda display rapidly shifting and shallow expression of emotions?

A. Yes.

Q. You have that one checked off?

A. That's right.

Q. And what is your evidence to support that?

A. I have observed it. There is some evidence of it in the various records; Lahner reports some of these rapidly shifting emotions.

Q. Where does -- could you specifically direct me to the entries in Dr. Lahner's reports that show shallow expressions of emotion or rapidly shifting expressions of emotions?

A. Yeah, rapidly shifting.

(Discussion was had off the record.)

A. Okay. On Lahner's report --

Q. Which report, Doctor?

A. This is the July 31st, '89, report, she reports under Mental Status that usually he has spontaneity and humor, but that he said that he was worried, fearful, that he avoided people, was uncomfortable around old friends, but was meeting new people with whom he was establishing, and here comes that word, "superficial" relationships.

Q. That refers to Mr. Reda's conduct after the shooting, correct?

A. That's right.

Q. Isn't it likely that that behavior was precipitated by the shooting?

A. No, I really don't think that it was.

Q. What evidence do you have that he engaged in that behavior prior to the shooting?

A. Well, the testing is a major source of evidence, all of his tests, mine, my MMPI's, Lahner's MMPI's, they point to a, histrionic personality. Once you know that a person has a histrionic personality, you then know that it developed by the time he was 18. It's just

a -- it's like meeting somebody with Down's syndrome. You just don't get Down's syndrome by being shot at. You get it from birth. The minute you know a person has Down's syndrome, you know he's had it since he was born. And the same when you know a person has histrionic personality or symptoms of it, you know the symptoms are long-term.

Q. So you're not actually basing your belief that Mr. Reda displays rapidly shifting and shallow expressions of emotions on any history or document, you're simply basing that on the Millon test and the MMPI?

A. On three MMPI's, the Millon, my observations and Psychologist Lahner's description of him.

Q. Of him after the shooting?

A. He wasn't examined before the shooting, so naturally.

Q. Okay. Did you ever talk to anybody, any friends or family of Mr. Reda, to find out if he displayed rapidly shifting and shallow expressions of emotions prior to the shooting?

A. I have talked with no one.

Q. Wouldn't you like to know that?

A. The more information the better.

Q. And again, I believe you said before usually the person that you ask themselves is probably the worst

historian?

A. I'm sorry, what?

Q. The person that you're evaluating is usually the worst historian.

A. I didn't say that. I did say that documents were better than the person's conversation.

Q. What about asking other people, is that a good way to find out?

A. It is another way. I like the documents better,

Q. You like the documents better?

A. Right.

Q. What documents would you look for to determine whether or not Mr. Reda was displaying rapidly shifting and shallow expressions of emotions prior to the shooting?

A. I know of none that exist,

Q. So the best information that would be available to anybody would either be Mr. Reda's description of himself or the descriptions as given by his close friends and family: would that be fair?

A. If there are no other documents, then those are relevant, His testing is also relevant, so --

Q. Would the length of relationships,

interpersonal relationships with others, also give you an indication as to whether or not he displayed rapidly shifting and shallow expressions of emotions prior to the shooting?

A. No, not necessarily. A person can be emotionally superficial and yet sustain a marriage or whatever.

Q. Now, I believe you have an asterisk next to -- what do you call that?

A. A caret or an arrow.

Q. -- next to 6, and then you also have one next to 7, which indicates that you also believe that Mr. Reda is self-centered, actions being directed toward obtaining immediate satisfaction; has no tolerance for the frustration of delayed gratification.

A. Yes.

Q. And, you cite as your example his drug use?

A. Right.

Q. Okay. Any other evidence that you have to support your opinion that he is self-centered and so forth, as set forth in paragraph 7?

A. The -- his school history, particularly his difficulties at Youngstown, are consistent with this immediate satisfaction and no tolerance for frustration.

He quit because he didn't like school.

Q. Many kids quit because they don't like school, don't they?

A. I would use the word "some" quit.

Q. Some quit because they don't like school, correct?

A. Yes, Most finish school.

Q. Mr. Reda finished school, didn't he?

A. Eventually he got a degree.

Q. Okay, And he went back and he got a degree in wildlife management, which he currently holds a pretty good position in, correct?

A. Yes, eventually he did that.

Q. Okay. Well, he went straight through Hocking Institute, didn't he, where he received his degree?

A. I don't believe so. I don't think he did. As I understand, he went *to* three different colleges over a period of about four years. They were Youngstown, Hocking, and Ohio University,

Q. Okay. And Youngstown he quit, and what did he do when he quit Youngstown?

A. On page 2 of my report, after he quit Youngstown, he worked for awhile and traveled and relaxed, really did --

Q. Now, did he work full time or part time?
A. I don't know.
Q. How much did he travel?
A. Don't know.
Q. Relaxed, what does "relaxed" mean?
A. It's what he told me, and so I'll have to leave that to him, what did he mean.
Q. Now, you also say he went to Hocking Technical College and he quit because of a dislocated knee and received more surgery?
A. Uh-huh.
Q. Where the heck did you get that information from?
A. From him,
Q. From him, okay. And you go on to say in 1981, he went to Ohio University, and he says he injured his back, was placed in a body cast for ten months, so he quit.
A. Yes.
Q. Okay. Do you know what type of injury he suffered?
A. No, I don't.
Q. Do you know how long he was in the hospital?
A. No, I don't.

Q. Do you know if he was able to attend school?

A. A body cast sounds pretty prohibitive to me, so I assume that he was not able physically.

Q. And then he got his job in 1983, February of '83, correct?

A. That sounds correct, yes.

Q. Are you saying that that history there that you just went through is evidence that he's self-centered and actions being directed towards obtaining immediate satisfaction, no tolerance for the frustration of delayed gratification?

A. I have said that his Youngstown experience exhibited a low frustration tolerance.

Q. Simply because he didn't like school and he quit?

A. Exactly. He didn't attend classes and made F's in other classes, yeah.

Q. And! the fact that he went to Hocking, completed his course of study and received a degree and then went on to a successful career indicates the opposite.

A. Well, it puts him back in the mainstream of sort of average people. I mean, I don't think it's any huge virtue; it's not a vice, either, It's normal.

Q. Well, most of us strive to be just an average person,

A. Yeah. I believe that this record is not the record of a -- certainly not of a highly-motivated person.

Q. Is not the record of a highly-motivated person?

A. It is -- I'll go farther. This is not the record of a person who has average motivation if you look at -- by record, I mean school record, three different universities, time off for vacation, not attending classes, got F's in other classes.

Q. That was just at Youngstown. That was just at one school.

A. I'm just saying the average person didn't get F's and fail to attend classes and quit his first college. I mean, it happens but not everybody does it.

Q. But you're ignoring his accomplishments before or after Youngstown State.

A. No, those I think are average. They're okay.

Q. Isn't it okay that a normal person without any type of personality disorder has a slip-up in their life?

A. Some more than others, yes.

Q. A perfectly normal-person, without any type

of personality disorder, can have a bad year in school, decide they don't like school, and drop out,

A. That one point by itself, sure. I mean, you can take any symptom, any weakness, and ask the question, Look, if a person had only that weakness, does that make him ill, and the answer is of course not. It's the string of all the other things. I'm maintaining it's a little bit odd to not go to class, to make F's, to go through three colleges, to use a variety of drugs, including cocaine all at the same time. There's something a little wrong with that. Not everybody has that in their history, only Supreme Court judges and a few others -- sorry, that was a joke.

Q. You're not using, then, his experiences at Hocking Technical Institute, Ohio University, and his work history with the Ohio Department of Natural Resources as any indication that he's self-centered and so forth?

A. Correct.

Q- You also are not using his experiences at Hocking Technical Institute, his experiences at Athens and his work experience with the Ohio Department of Natural Resources to refute that he has a personality disorder or tendencies towards a personality disorder?

A. Right. Right. I'm not holding those up and

saying he does this, this proves he does not have a disorder. Obviously, I think he does have the symptoms.

Q. You're focusing in on the Youngstown experience, correct?

A. I am using that as one piece of evidence. I am not -- with so many other pieces of evidence.

Q. Now, the last paragraph, 8, you have a question mark by, "Has a style of speech that is excessively impressionistic and lacking in detail, e.g., when asked to describe mother, can be no more specific than, "She was a beautiful person."

Now, that was -- that entire quote is from DSM-III, right?

A. Right.

Q. Just a question mark next to that one, why is that?

A. I got the impression in talking with him that his speech was impressionistic and lacking in detail, and an example of that would be his notion that his dreams of the incident were abstract, unquote, and I really did try to pursue that, "What do you mean, they're abstract," and the response I got, "Well, they're abstract," and that was one of several example of impressionistic speech.

Q. What other example can you give us?

A. I can't remember other specific examples -- give me a minute.

Under behavior, I list that he seemed evasive. Impressionistic speech has that evasive quality about it.

Q. Give me some specific examples, though, Doctor.

A. I already gave you one. A second one would be that at first he said -- when I asked him to talk about the incidents, he said, "Well, I just don't remember much." He may have gone on to say, as I recall, something like, "It was just a tough experience," and it took me awhile, but as I prodded away, he went ahead and filled in the so-called rough experience with the details that I have listed in the report.

Q. That's not unusual talking to people, is it?

A. I think it is, particularly for the victim of -- most victims of post-traumatic stress disorder, they will recount the incidents in detail.

Q. He was able to recount it to you in detail, was he not?

A. After prodding. I mean, I knew he did. He had told Psychologist Lahner about this; it was all over the records. Truthfully, I didn't buy the notion that he

couldn't remember, I just didn't buy it, and he could remember it. And it just took me probing, and then he did,

Q. And he remembered?

A. Yes.

Q. Any other examples that you can think of?

A. No.

Q. Doctor, do you ever tell your patients not to read up or to get more information on the types of disorders or illnesses that they have?

A. No. Quite the contrary, I encourage that.

Q. Do you think it is a good idea if the person reads articles, reads other information, talks to other people about their particular disorder or condition?

A. Yes.

Q. Now, the MMPI that you gave after Mr, Reda's treatment was done, you wouldn't *expect* that to be consistent with post-traumatic stress disorder, would you?

A. No, it is not consistent.

Q. You wouldn't expect it to be, either, since it was taken after he had completed his treatment and was in remission.

A. That's right. If he were truly in remission, then his profile would be inconsistent with it, right.

Q. And you would expect that?

A. Right. Keep in mind that his profile two months after the incident, the shooting, before he had received treatment, that profile was equally inconsistent with the MMPI's of post-traumatic stress victims.

Q. Do you diagnose in your practice simply based upon the MMPI?

A. No.

Q. You have to rely upon the history that you obtain from your patient?

A. Correct.

Q. The other documents that you obtain on your patient?

A. Right.

Q. The other tests that may be administered?

A. Right.

Q. Anything else?

A. The person's behavior in the session, of course.

Q. Anything else?

A. No. How those three things, history, behavior, and testing, how they fit in with the criteria determine the diagnosis.

Q. And a person very well may act differently

for you while you're evaluating them than they will for their own treating psychologist, correct?

A. Those differences would be very subtle. Generally, I would say no to that question, that the behavior's pretty consistent across doctors, hence the fair level of agreement of second opinions and so on.

Q. Well, you examined Mr. Reda for a specific purpose for this lawsuit. Wouldn't you expect him to be a little bit leery of you?

A. I would expect him to be leery of me, yes.

Q. Wouldn't you expect him to be a little bit defensive?

A. A little, yes.

Q. Okay. Wouldn't you expect that to affect his attitude towards you?

A. Yes.

Q. Wouldn't you expect that to affect his behavior while in the interview?

A. A little. I must add, I would expect the presence of a mental illness to affect his behavior more.

Q. Are brave and anxiety mutually exclusive emotions or feelings?

A. They are opposites.

Q. They are opposites?

A. Yes,

Q. You are saying that a person who acts bravely is not anxious while they are acting bravely?

A. Certainly a person who is acting bravely can and probably does feel anxiety. The question is whether they're -- is whether you could then describe a brave person as having more anxiety than average, and indeed, whether the anxious person has an anxiety disorder, and the answer to that question is heavens no. I mean, a person who is anxious is anxious. A person with pathological anxiety doesn't act bravely, they act anxious, and there's nothing in the criteria anywhere that indicates that an anxious person behaves bravely. They behave anxiously.

Q. You're speaking of an anxious person who was anxious to the point of having a personality disorder.

A. Anxious to the point of having a psychological disorder.

Q. Psychological disorder?

A. Right.

Q. Okay. What about a person who is anxious within the normal bounds of psychological health?

A. Again -- I mean, I hate to seem sort of blunt on this, but we're talking now about fundamental

semantics. When you say somebody is anxious, what do you mean. You mean they are -- you just list it -- timid, fearful, not bold, not brave, not fearless, fearful -- fearful, not fearless. I mean, this question -- if we had a physical analogy, it would be like asking isn't it true that a person who has got a damaged foot runs marathons. No, that's what we mean by damaged foot.

Q. Well, when a police officer acts bravely in the line of duty, could he not also be anxious while he was acting bravely?

A. Yes, but the probability is practically zero that a brave-acting police officer has a -- anything approaching a mental health disorder in the anxiety direction.

Q. Isn't "bravery" a word that is used by others who perceive the act?

A. Well, what is the definition of "bravery"?

Q. What I'm getting at, can't a person be scared to death and still dive into the river to save that other person?

A. Yes. It is much less likely that that act would be done by somebody that suffers from an anxiety disorder.

Q. I'm not talking about anxiety disorders, I'm

talking about what we would consider normal people.

A. Again, somehow this is getting all tangled up when, in fact, it's very simple. Anxious people don't act bravely. A person who is highly brave may do things that raise his anxiety level. But if a person's got a problem with anxiety, he has a problem with anxiety. He is fearful; he is scared; he does not engage in brave activities. The more anxious he is, the less bravery he shows; the more calm he is, the more bravery he shows. It's really quite simple. These are opposite ends of the continuum.

Q. Bave you ever read any literature or have you ever done any investigation to determine whether police who suffer from post-traumatic stress disorder engage in activity that is I guess you would describe it as reckless in your report, in an attempt to overcompensate for other areas which they *shy* away from because of the post-traumatic stress disorder?

A. No, I've never read such articles.

Q. Do you know whether or not that is a symptom, or --

A. It is not a symptom. Look at the --

Q. Does it occur in police officers or others who suffer from post-traumatic stress disorder?

A. DSM-III-R suggests or most emphatically indicates that the exact opposite is true, the exact opposite. These people recoil from reminders of the trauma.

Q Have you ever read any studies or any research that was based strictly on police officers and post-traumatic stress disorder?

A. No. I recall none based on just police officers.

Q. Do you believe Mr. Reda suffered any type of a psychological effect as a result of the shooting incident?

A. No.

Q. Do you think the shooting incident affected him in any way psychologically, emotionally?

A. No.

Q. Do you think that he got over the event immediately?

A. I believe there was nothing for him to get over.

Q. Can you explain that answer further?

A. Yes. After the event he acted calmly. He discovered later that he was injured, seemed casual about it: went to the emergency room to make sure everything was

okay; went right back to the scene of the shooting, handled another situation there; went to the scene of the shooting a couple of days later. I mean, I can go on and on, but what I'm trying to tell you is that there's no evidence that it had any detrimental effect on him.

They said, "Take off from work, Reda," and he said, "NO, I don't want to." He went back to the scene again with an investigator, continued to function in his job, began to take more risks, if anything, as a narcotics officer, got in that sticky situation with the double billing.

This is not a timid guy. I don't see one piece of evidence from his behavior, outside of his conversations with Lahner, I see no evidence that he was affected by the incident. In fact, it's quite the opposite. He was just as bold as ever.

Q. What conversations outside of Dr. Lahner are you referring to?

A. Well, my statement was that other than his behavior with Lahner, I see no evidence. The other evidence I'm referring to is his own statements to me that he continued to be a narcotics officer; the newspaper articles, you know, indicate that this is not a guy that was slinking away from things. He was still willing to

take those sorts of risks with his personal life. This is not a timid guy after the shooting, neither in the minutes after the shooting, in the hours and the days and the weeks and the months,

Q. Did Mr. Reda describe for you any difficulties he had in his life following the shooting?

A. Yes. You know, I mention in my report that he reports problems.

Q. Such as?

A. For example, with Lahner, he reported distressing recollections *of* the event. My problem is he just doesn't -- there's no behavior to corroborate that, and, in fact, there's behavior to contradict it. If he had horrible -- here we've got a guy who's saying, "Man, there's times that I think about being shot and it's so painful that I can't even concentrate."

"Well, what were you doing at the time?"

"'Well, I was on a narcotics raid that I chose to go on," or on the job that I'm choosing to stay at.

Q. When does the onset of PTSD, post-traumatic stress disorder, occur?

A. Anywhere from immediately, that's the usual pattern, immediate onset, up to what's called delayed onset. Delayed onset can occur, after, I think, six

months. I think it's six months,

Q. Can post-traumatic stress disorder set in at any time in between immediately and six months?

A. Yeah, in fact, even after six months, although it's increasingly rare.

Q. Can post-traumatic stress disorder set in two week after the traumatic event?

A. Yes.

Q. Can it set in two months after the traumatic event?

A. Yes.

Q. Okay, During the period between the traumatic event and the onset of post-traumatic stress disorder, does the person, for lack of a better term, operate normally?

A. That's essentially correct. There are -- there's some evidence, and I can't recall where right now, but some evidence that they begin to have avoidance of the situation pretty much immediately, but the full-blown nightmares and so on may be delayed for six months and even more.

Q. So during that time a police officer, during the time of the traumatic event and the onset of PTSD, may stil be able to be a police officer, he still may be able

to make arrests, go on emergency calls and so forth?

A. Yes.

Q. It's not until the onset of post-traumatic stress disorder that those functions become affected?

A. That's right.

MR. DeROSA: Okay.

MR. MORAN: Thank you and good night.

(Discussion was had off the record.)

MR. DeROSA: After five hours, I think I'm done.

Doctor, I have a feeling you know what waiver of signature means.

THE WITNESS: Yes.

MR. DeROSA: Do you want to review the transcript, or will you waive signature?

THE WITNESS: I'm certainly willing to waive, I don't have any --

MR. DeROSA: I don't have any objections.

MR. MORAN: I would suggest you not waive, but that's up to you.

THE WITNESS: Let me rethink this for a moment.

MR. MORAN: But I'm not your lawyer.

THE WITNESS: Come to think of it, I better sign on this thing and not waive signature.

MR. DeROSA: Can you please type that up and provide it to Dr. Layne.

(Deposition concluded and witness excused at 5:15 p.m.)

CHRISTOPHER LAYNE, Ph.D

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SIGN HERE

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TO THE REPORTER:

I have read *the entire* transcript of my deposition taken on the 18Th day of July, 1991, or the same has been read to me. I request that the following changers be entered upon the record for the reasons indicated. I have signed my name to the signature page and authorize you to attach the same to the original transcript.

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C E R T I F I C A T E

I, Casey Gotthart, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, CHRISTOPHER LAYNE, Ph.D, was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given was by me reduced to stenotype in the presence of said witness and afterwards transcribed; that the foregoing is a true and correct transcription of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, counsel or attorney of any party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Toledo, Ohio on this 30th day of July, 1991.

Casey Gotthart

CASEY GOTTHART
Notary Public
in and for the State of Ohio

My Commission expires December 2, 1991.