BYROM, ET AL. V. SCHNEIDER NATIONAL CHRISTOPHER LAYNE, PH.D., 9-1-94

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
WESTERN DIVISION

JOHN BYROM, et al.,)
)
Plaintiff,)
)
vs.) No. 3:91-CV-7111
)
SCHNEIDER NATIONAL CARRIERS, INC., et al.,) Judge Avern Cohn
)
Defendant.)

- - -

DEPOSITION OF CHRISTOPHER LAYNE, PH.D

DATE: September 1, 1994 at 12:41 p.m.
PLACE: 2800 West Central Avenue
Suite A
Toledo, Ohio
REPORTER: Tracy L. Spore, RPR
Notary Public

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(Court Reporter marked Defendant's Exhibits 1 through 3.)

- - -

CHRISTOPHER LAYNE. PH D ,

A Witness herein, called by the Defendant as if upon Direct Examination, was by me first duly sworn, as hereinafter certified, deposed and said as follows.

DIRECT EXAMINATION

BY MR BORELL.

Q. Doctor, would you please give us your name and professional address.

A. Christopher Layne, 2800 West Central Avenue, Toledo.

Q. What is your profession?

A. Clinical psychologist.

Q. Are you licensed as a clinical psychologist in Ohio?

A. Yes.

Q. How long have you Seen licensed?

A. Since 1980.

Q. And how long have you been ai your present address?

A. I've been at this address for about one week; we just moved.

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Q. And prior to moving here what was your professional address?

A. It was 3450 West Central, about four blocks from here.

Q. Doctor, would you please give the Court a description of your educational background. and could you please begin with your undergraduate work.

A. I got a bachelor's degree with honors from the College of William and Mary, then I got my master's degree and Ph.D. from the University of Alabama. I took an internship at the University of Alabama Medical Center In Birmingham, and then went on to teach at universities and get involved in private practice.

Q. Do you hold any certifications in psychology?

A. Yes. Besides my licensure I am board certified In clinical psychology from the American Board of Professional Psychology.

Q. And would you please explain to the Court how a psychologist becomes board certified.

A. That's the advanced certification in our field. After five years you quality to attempt to get certification; you submit your credentials, and you also submit an extensive sample of your work If you pass that

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phase of the exam, then you are examined all day long by three board certified clinic21 psychologists. On the basis of all of that they determine whether or not you get certified.

Q. When did you become certified?

A. 1980.

Q. Are you associated with any universities?

A. Yes, I'm a tenured professor at the University of Toledo in the psychology department

Q. How long have you been associated with the University of Toledo?

A. Since 1980.

Q. Do you also maintain a private practice?

A. Yes, I do.

Q. How long have you maintained the private practice?

A. Since 1970.

Q. How much of your professional time. Doctor, in psychology is devoted to litigation matters such as is the reason we're here today?

A. If you take into account my university work and then also my patient contact, probably one-tenth, maybe one-eighth of my work is Ikigation-related.

Q. Thank you. Have you published any books?

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A. Yes; two.
Q. What are the titles of those books?
A. One was "Know your Psychological Experts," and the second was a psychological torts manual.
Q. Those two books sound related to litigation, is that true?
A. That's correct.
Q. Have you also published any articles?
A. Yes, I published about 40 in internationally circulated Journals;those are on psychologicaltesting, depression and children.
Q. Are those related to litigation in any way?
A. No.
Q. Doctor, at the reqoesi of the attorneys for the defendant did you examine :he plaintiff in this case, John Byrom?
A. Yes, I did.
Q. And when did you conduc: that examination?
A. September 3rd, 1993.
Q. Where did that examination take place?
A. At my former office on Central Avenue.
Q. And a?the time of the examination did you take a history from Mr. Byrom?
A. *Yes.*

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Q. Would you relate to the Court, please, the history that Mr. Byrom gave you.
A. Yes. In relating this I'll be referring to a mental heakh problem that I will call a hypochondriacal problem, and so that might help us to organize the history that I'm about to talk about.
I reviewed about 50 pages of documents and then interviewed him, and on the basis of that information I discovered that he had the history, the childhood experiences of a person that was going to become a hypochondriac, essentially. His father forced him to work so hard that his siblings realty thought it was nearly abusive. He worked about four hours everyday when he went to school, and when he wasn't going to school he was working about 11 hours a day, and this was when he was age six. He managed to get through school up to the 11th grade, at which point he quit and entered the Army. M e r he got his GED, though. He then went off to Korea, and then after coming back from the Korean conflict he worked a whole lot of manual, routinized jobs for pretty much the rest of his life up until recently. And the reason I bring that up is that often hypochondriacal people have a history of fairly simple but grueling work requirements. Okay.. So that's his work history

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Now let's look for a minute at hts physical disabilities before this accident.
Q. You're continuing on with your history now?
A. That's right. I'm continuing with the history.
Q. This is information Mr. Byrom gave you?
A. Correct, or I got from the documents.
Before the accident he had a brief brush with death when he was about two; that's probably not terribly important now, but what is important is that at age three his parents got him to start smoking; by age six he was clearly addicted to nicotine and was smoking about a pack a day.
Q. Why is that significant?
A. Well, because later he developed emphysema. and a lot of his problems now, I think, are related to that fairly harrowing diagnosis and the problem of emphysema; realty. it's roots were laid in a fellow that started smoke at age three.
MR. SCOT Im going to object and *move to* strike the last part outside this doctor's expertise
e?, A. The most Important piece of his health history before the accident was Korea where he was shot in

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the left leg, and a physician pronounced him ten percent disabled. That's important because after the accident he would be pronounced as six percent disabled, and so roughty - I think it's fair to say that his level of disabllty didn't go up after the accident. One could argue that it went down from ten to six percent, but I suppose that's quibbling.
MR *SCOTT* I'll object and move to strike as to his disability, being outside *this* witness's expertise
Q. Is a there a psychological significance to the level of disability?
A. Sure. The psychologists in this case are battling to some extent over the notion that physical disability causes mental illness. I believe Mr. Byrom would argue that his psychological problems are the result of what he believes are physical disabilities caused by the accident. So it's important for me not to ignore what the physicians are saying in this case.
Q. So using that type of information, is that unusual in your field?
A. It's not only not unusual, we're really required to use it. We would be remiss if we didn't take the opinions of physicians into account.

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Q. Continue on with :he history that he gave you, Doctor.
A. Okay. He had two other stressors in his life besides the hard work and the physical problems, particularly being shot and getting ten percent disabled in Korea. His third sort of cluster of stresses were two divorces.' He married in 1954, but the marriage turned sour, and he was divorced relatively quickly, and then lost touch with his daughters entirely. Then had a second marriage about a year later and zigzagged in and out of this relationship right around the time of his accident, and I mean only a month or two before he separated from his wife, and months after the accident he divorced his second wife. So that was a major stressor occurring all around this accident.
And that realty concludes the major points of this fellows life before the accident. and the next part of his history involves the accident itself.
Q. And did he describe the accident to you?
A. Yes, he did, and I also looked at records on the accident Four years ago he was sleeping in his truck when he was rear-ended or at least hit by some other truck He described the accident as one that threw him around, but I noted that he didn't act injured after the

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accident; he didn't even act dazed. Instead, what he did was something that was quite alert and adaptive; he rushed out of his truck in order to catch the other driver. He had a suspicion that maybe the other driver would leave, so he decided to go out to catch the person who had hit him. He found the other truck driver. The other driver called the police, and Mr. Byrom went back Into his truck and got dressed. Again. rational, physically competent behavior.
When the police arrived he did complain of some pain, but he refused to go to the hospital and instead went right back to work. He got his truck fixed, phoned his employer and his insurance company, took some Tylenol, and then drove 500 miles. That driving stint lasted trom 9:00 a.m. until midnight. Now, I need to emphasize that particular window of events. This was an accident wherein which after the accident he responded immediately with adaptive behavior. catching the other driver, then getting dressed. then refusing to go to the hospital, then working ail day in a sitting position driving a heaw truck- There's several conclusions we can draw from that: the main one that is clearly within my area of expertise -
MR SCOTT Before we get to this Im

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going to object just so you know or the record
MR BORELL What's your objection going to *be?*
MR SCOT Obviously *there* s no question **as** to opinions *yet,* conclusions **that** may *be* drawn or may not be *drawn* We need to get to the right form I think
BYMR BORELL
Q. Doctor, during your testimony today I may ask you some questions for you to give an opinion or a conclusion. or you may on your own render a conclusion or an opinion. Would you please make all of those opinions - would you please express them to 2 reasonable degree of psychological certainty.
A. okay.
Q. So anytime you give an opinion or conclusion, it nus! be to a reasonable degree of psychological certainty
A. Okay. All right.
O. *Would* you *then continue on, Doctor.*
A. Sure. The relevance of all of that behavior Is thls, That It Is my opinion to a reasonabie degree of psychological certainty this is not behavior of a person

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that suffered brain damage; this is not behavior of a person that suffered from a trauma that was ***so*** psychologically damaging that later it would cause some kind of mental illness. It is instead the behavior of a person who is reacting normally and adaptively to a minor trauma: getting dressed, looking for the other driver, going on back to work. Okay.
*O. Does that conclude **the** history portion that* you took *during the exam?*
A That concludes the history up to and Including the accident, but then there's more history after the accident, *what* happened to him after the accident.
Q. Okay. Then continue on with that history as it relates to after the accident.
A. When he finished his day's work, fairly grueling **day's** work. he did complain of more pain. He went home but still waited two days before he even called a physician at all. He never went to the hospital during these early days after the injury. After the accident the stressors that had begun to emerge before the accident, **that** is to say unrelated stressors, increased.
*O. You **have** used the term stressors Could you explain to the Court what you mean by that?*

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A. Yeah. I just mean traumatic or stressful, emotionally stressful events, events that muse emotional distress. Again, it's relevant here **because** this ***case*** in my mind revolves around the question of the psychological significance of the accident as opposed to, of course! other stressors in his life. Within 16 **months** of this accident on one side or the other he was separated from his wife; he got a new job at a new trucking company; emphysema was diagnosed - and by the way, he kept right on smoking; he endured his second diorce; he got irritated with his former lawyer; he broke his ankle and was in a ***cast*** for six weeks. Again, my point here is that those are all individually fairly important stressors. And I have in tact. a chart that Illustrates that.
*Q. **Let** me hand you, Doctor, what's been marked Defendant's Exhibit 3. Do you recognize that?*
A. Yes, that's from my report.
Q. Would you *explain to the court what that chart is or what Defendant's Exhibit 3 is.*
A. Yes. This is, again. a chart from my report. And what it does is it makes the point, the overall point that stressors can be rated on a scale. We don't have to ***list*** stressful events and then speculate about them: we can rate the intensrty using one of two

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different kinds of scales. One scale that we can use is the famous Holmes & Ray scale; that's the first column in thetable.
O. Jus! briefly explain to the Court what you mean by the Holmes scale.
A. Actually, It's been popularized. and that's sort of unfortunate because it's actually a very good and precise scale, and it's been popularized, and so many of us have seen this in magazines. You rate your stressors, and people will - jokingly people will say. I have had 250 points or I had 300 points during this last five years, or whatever. And magazines will urge you to rate your stress level. But the scale itself is really a quite reliable and **good** scale. And I have rated his stressors on or near the accident in time, and I've come up with on the Holmes scale a divorce is 73 points, separation is another 65 points, a job loss and a new job is 47 points, the diagnosis of emphysema is 53 points, broken ankle is another 53 points. and if he were -, if he had been physically Injured in the accident of April '89, if he were physicalty injured, then he would get another 53 points for that. And ***so*** my overall point is that on the Holmes scale his total unrelated stressors come to 291 points whereas the stressor *of* the accident of April

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'89 - again, assuming that he was physically injured in that accident, a dubious assumption -
MR. SCOTT: Objection. Move to strike.
A - but assuming that, he gets another 53 points for that.
Q. Doctor, would you explain to the Court !he psychological significance of the scores that you just related to us remembering, again, that any opinion or conclusion that you give must be to a reasonable degree of psychological certainty.
A. To a reasonable degree of psychological certainty I can say that Mr. Byrom's stresses on or near the accident were primarily unrelated to the accident and that at its worst the stress levels caused by the accident are fairly insignificant.
MR. SCOTT: Objection. Move to strike.
Q. You also have a second set of *numbers called a DSM scale.*
A Right
Q. Would you explain to the Court what the DSM scale is.
A. Well, it is just another way to rate the

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stressors. It's similar to the Holmes-scale in that it is a quantification of stress levels. It doesn't agree perfectly with the Holmes scale, but on the other hand agrees reasonably well. And that scale is found in the DSM-III-R, the diagnostic and statistical manual that we all use. Under that stress scale his accident *at* its worst would give him five stress points, f i e points of stress, and his other stressors would give him 20. So it doesn't *matter* ***which*** stress scale we look ***at,*** in either *case* to a reasonable degree of psychological certainty the accident is relatively less stressful than the cumulative effect of his other stressors in his life.
O. Doctor, as part of your examination did Mr. Byrom also *relate some physical complaints to you?*
A Yes. Investigating his history he first told me about and confirmed *what* the physicians records had already suggested to me, and that is that he had compiained right after - right after his accident he complained of several odd problems and some other problems that would make a little more sense.
Q. Before you continue on with his physical problems, is !he-e a psychological reason why you would ask him his medical problems?
A. Once again, I'm basically required to do

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that. I would be remiss in my duties as a psychologist to ignore the opinions of physicians. So what I try to do in my report and here today what I tried to do is to make clear that when I talk about physical illnesses, I'm talking really about the opinions of physicians, not my own opinion.

Q. You, of course, did not reach any medical conclusions yourself?

A. No. And I make that statement in the report quite carefully. I make no medical opinions in the report.

Q. And I correct that you're using medical diagnosis to reach a psychological conclusion?

A. That is correct. I want to emphasize I would be remiss to do otherwise. It would be downright foolish for me to take the position that although he's been seen by physicians and although there are physicians' records available, I will ignore those records. That would be a foolish position for me to take.

Q. Would you continue then, doctor, and relate to the Court the physical complaints that Mr. Byrom related to you.

A. Yes. Not only the ones he related to me, but what the record said. He complained of cervical pain,

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neck pain in general. stiffness, a numb right shoulder, tingling right fingers. Then he complained of headaches, more neck stiffness. Then he complained of ringing in his ears. And then he complained of problems urinating. And then much later, over two years after his accident, he began to complain of blacking out and passing out, and those problems really emerged over two years after the accident.

G. Go these physical complaints and the time frame in which they appear that Mr. Byrom related to you of that appear in the medical records, do they have a psychological significance?

A. Yes, particularly the blackouts and passing out two years after an accident where even at the time he didn't lose consciousness.

Q. What is the psychological significance of these complaints?

A. Many people with hypochondriacal disorders claim that they blacked out or that they black out. It's a sort of typical hypochondriacal complaint that goes right back to our stereotypical southern belles who get a case of the vapors and have to sit down and swoon. It has about it a hypochondriacal quality. As I mentioned earlier, I would be remiss in not noting that his medical

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tests were normal. The physicians' reports, x-rays and spine MRIs and neurological exams were all in the normal range. It's important. I think. for me to pay attention to those findings of physicians given the fact that here we have somebody that's complaining of a disabling physical problem, and yet medical tests are normal.

Q. Would you explain to the Court how that has a psychological significance.

A. That is almost the definition of a hypochondriacal person. I say almost the definition of a hypochondriacal person. that they complain of physical problems but there are no objective signs of physical disease or physical disability. The diagnoses of him, I tried to pay attention to those physicians' diagnoses, but the problem is that they seem to disagree one with the other, which leaves me in a kind of quandary. Dr. Simon diagnosed cervical strain; sexual dysfunction; and of course the ankle fracture later, and that was an unrelated problem. Dr. Rogers diagnosed what's called cervical pain syndrome, which as I understood Dr. Rogers' report of May. 1989, cervical pain syndrome means that this man complaints of a lot of pain around his cervix.

Q. That's your understanding of Dr. Rogers' diagnosis?

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A. Correct. Correct. A therapist named Hatfield noted muscle spasms and range of motion contractures. A Dr. Stein diagnosed a possible nerve root impingement. The point is that I could find no consistent medical diagnosis.

Q. And what is the psychological significance of that inconsistent medical diagnosis?

A. Well, then I'm led –

MR. SCOTT: Before you get to that, I'm going to object again and move to strike because I don't think this witness has the expertise to comment on the orthopedic surgeons involved in this case or whether their separate diagnoses are consistent or not.

MR. BORELL: Go ahead, Doctor.

A. A set of diagnoses that are not consistent; that is to say they're not the same words, not the same diagnostic category, increases the probability that the person has a hypochondriacal problem; it decreases the probability that it's a genuine physical problem. For example, if he were diagnosed consistently with a broken spine after the accident, if everybody who saw him saw a spinal fracture, that would then give much more credence

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to his real physical complaints. But that's not what I'm seeing here.

Q. Doctor, are psychologists trained to make psychological conclusions of evaluations based on medical diagnoses that are made by other people?

A. Yes. And not only are we trained to pay attention to what physicians diagnose, but as I said, in addition, it goes much farther than that; we must pay attention to those variables. We would be negligent if we did not.

Q. When you say 'must,' would you explain to the Court what you mean by that.

A. Yes. Maybe I can do it by use of an example. If someone came in and said that he felt nervous and sleepless, and then he also mentioned that he had been diagnosed with hyperthyroidism, it would be foolish for me to diagnose anxiety without first confirming that he had, indeed, received a diagnosis of hyperthyroidism. The reason is the hyperthyroidism can cause anxiety symptoms and sleeplessness. So I am required to pay attention to what the physicians diagnose. There's so many other examples of drug side effects or medical problems that mimic the symptoms of depression or psychosis or anxiety.

G. So as a psychologis: the:I you have some

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training in understanding medical diagnoses, at least how they interrelate with psychological problems?

A. Correct. Yes. Yes. But we don't offer any opinions about the medical problems; instead, we rely on the opinions of physicians. And all I'm saying here is the physician opinion is that medical tests are normal; the physician opinion is that there are a number of complaints. And when it comes to the diagnostic categories, they are not consistent in the sense that the physicians are using different words to describe this person's diagnosis.

Q. And your comments and testimony on the physicians' diagnoses are related then just to the psychological impact of that?

A. Right. Right.

Q. You have not made any independent medical diagnosis?

A. Not at all. I have never made an independent medical diagnosis and would not do that. That wouldn't be a correct thing to do.

Q. During your examination of Mr. Byrom did he mention an impotence problem to you?

A. Yes.

Q. And what did he tell you about that?

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A. He said that that problem emerged a bit later after the accident. and he told me that at the time of my Interview that his impotence was by far his major problem, that he had gotten over his depression.
O. Mr Byrom then also discussed depression with you?
A. Right- He said that he had gotten sort of depressed earlier but that the depression had gone away since then.
Q And I'm no: sure I asked you this, but what was the date of your examination of Mr. Byrom?
A. September 3rd, 1993.
O. Did you also have a:: opportunity during your exam to observe Mr. Byrom s behavior?
A. Yes.
O. And as a psychologist are you trained to observe the behavior of a person then make a ,psychological interpretation or diagnosis of that behavior?
A. Yes.
O. What behavior did you observe from Mi. Byrom?
A The two most important things were that, number one, he just didn't look depressed; he never cried; he never appeared sad; he didn't hang his head; his voice

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was sufficlemtly loud; his gestures were animated; he smiled; he laughed at jokes; he was cordial. He showed none of the typical face-to-face symptoms of depression.
O. And as a psychologis! you have been trained to recognize physical symptoms of depression?
A. Yes. Behavioral symptoms too.
Q. Behavioral symptoms. are those the symptoms you just mentioned?
A. That's correct. Yeah. On the other hand his behavior conformed quite nicely to a diagnosis of a hypochondriacal problem. People who have these kinds of problems are typically breezy; they're sort of defensive, that is to say they realty don't want to talk about their emotional problems very much.
O. You've used the tern "hypochondriacal" several times. Why don't we bke a moment - I know you'll talk about it later - to explain to the Court what that tern means.
A. There is a real mental illness out there suffered by a substantial portion of mentally ill people that consist of exaggeration of physical problems. The mechanism whereby the mental illness comes into being is really explained by the term "secondary gain." What it all means is that if I have a hard life, if I have to work

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very hard, if I'm pushed to work hard by my father, then I undergo a io?of stress, I begin to want to escape from It. I have Several choices; normal people go out and attack the stressors and modify them or change them or get rid of them. Other people react by withdrawing in one way or another; they get drunk a lot and the booze takes away the stress, at least temporarily. Other people imagine that they have physical illnesses because by doing that they get a break they don? have to work anymore: they get sympathy from their family; they develop what's called a sick role so people treat them with lots more respect and lots more indulgence; they don't get many demands; and if somebody does dare to demand something from them, they say. Look, I can't do it because I'm sick. I'm physically sick So the claim of physical illness is not a lie; it's a coping technique much like getting drunk Is or becoming an alcoholic whereby the person avoids responsibility and gets rest; they get to go to physicians and get medicine and all sorts of things. So that's the mental illness that I call hypochondriacal.
O. That is a psychological illness?
A Right Now, the technical term that we should be using here is somatdorm pain disorder. and I'll talk about that later. But a somatoform pain disorder is

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a hypochondriacal disorder.
O. Doclor, as part of your evaluation of Mr. Byrom did you examine tests that were performed by a Dr. Copple in Tennessee?
A. Yes.
O. Do you know when those tests were performed?
A. Yes, Dr. Copple performed the test -
MR. SCOTT: It's Copple
A. I'm sorry. - in October of '91.
O. What test did he administer Dr Copple?
A. He administered two tests. both of which are very good tests. One is the Beck Depression Inventory, and the other is the Minnesota Mukiphasic Personality Inventory, which is called the MMPI.
O. Would you explain to the Court what the Beck's Depression - is it Inventory3
A. Uh-huh.
O. Would you explain to the Court what that is.
A. It was a good test to administer to Mr. Eyrom because the question is, Is he depressed. The Beck Depression Inventory is a test that specifically measures depression, and so it was a good choice.
Q. And did you review that tes: as it was administered by Dr. Copple?

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A. Yes.
Q. And you have several documents or several exhibits in front of you. One is labeled Defendant's Exhibit 1.
A. Uh-huh.
O. Would you explain to the Court what Defendant's Exhibit 1 is, the lop chart.
A. Yes. It is - well. Defendant's Exhibit 1 is my administration of the personality assessment inventory.
O. What is Defendant's Exhibit 2?
A. Exhibit 2 is a combination of two MMPIs, the one they administered and also the one that Copple administered earlier. Now, what is not on either one of these two exhibits, what is not on either one of those is the Beck Depression Inventory.
Q. What were the results of the Beck Depression Inventory as administered by Dr. Copple?
A. He, Mr. Byrom. scored normal on the Beck Depression Inventory; the significance of that I cannot overstate. Apparently Dr. Copple went into this test wondering if Mr. Byrom was depressed; he therefore wisely chose the Beck Depression Inventory. What he found with this inventory was that Mr. Byrom is not depressed. I

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think that's significant and interesting. You have to keep in mind I did not diagnose depression because I take this test seriously.
Q. How is the Beck's Depression Inventory rated or analyzed? How does one do that?
A. It's really quite simple; the test taker responds to a number of questions about depression, and then his responses are added up. And Mr. Byrom scored six, which is clearly in the normal range.
O. And the six was the score that Dr. Copple attributed to the test?
A. That's right. That was Cr. Copple's discovery, not mine.
Q. Now, there was a second test that was administered by Dr. Copple, and that was the MMPI?
A. Correct.
Q. And, of course, you also administered an MMPI; is that correct?
A. That's correct.
O. Would you explain .D tho Court what an MMPI is.
A. Yeah. It's an objective inventory. The important point that the Court should be aware of is that there's several ways for us to evaluate Mr. Byrom; we can

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talk to him and get a kind of intuitive feel for the way he acts; we can review his records and his history and get some kind of a feel for what his psychological problems are based on his history: and in independence of those other two methods, we can test him, we can give him psychological tests.
Of the three methods: history. behavior and testing, by far the most accurate is testing. The reason testing is the most accurate is that it doesn't depend on my intuitions or Dr. Copple's intuitions, instead it's an objective set of indicators.
Now, the Beck is objective, and the MMPI is objective. In the case of the MMPI, it's about 560 questions; they're all true/false. Mr. Byrom sat down and answered each of these 560 questions either true or false. He put his graphite from his pencil into a true or false column in every case. And then it was the job of Dr. Copple and I to simply add up his trues and fakes in different combinations to come up with these scales. So the graphs that you see in Exhibit 2 are not some intuitive concoction on the part of Dr. Copple or myself; Instead they are graphs that are objective, really generated by the test. And then the interpretation should be quite objective because the Interpretation should be

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based on atlases of MMPI profiles that are available to all psychologists. And that's what I did; I simply go to the book or the books and look up what the profile means, and that's what I did in my report.
Q. And Defendant's Exhibit 1 is the scores that Mr. Byrom - the results are Mr. Byrom's?
A. Exhibit 1 is Mr. Byrom's profile on another personality *test* called the Personality Assessment Inventory. I don't have these profiles labeled, and that's the problem. I should have labeled them, and I didn't.
Q. Explain to the Court then what Defendant's Exhibit 2 is.
A. Defendant's Exhibit 2 are two MMPI profiles, those of Dr. Copple and myself. The striking thing about these profiles is that although the *tests* were administered three years apart. they are remarkably consistent. Administered three years apart and by two different psychologists, and yet if you look at them, they're pretty much in lock step one with the other; I believe that there's not a dime's worth of difference between those two profiles. And Dr. Copple's deposition also suggests that; the profiles for all purposes are identical.

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Q. Would you explain to the Court what that chart means? What are the findings as a result of that test?
A. It shows roughly over a three-year period this man has scored a peak on a scale called hypochondriasis. Now, just as a side matter, the first three scales, the three scales at the top of that chart, are called the validity scales, and they ask the question, Well is this profiie valid; does this profile really tell us what Mr. Byrom is like. And the answer is that, Yes, he scored In the normal range. These three scales - the normal range, by the way, is the shaded portion of this graph, and that's true for the other - for Exhibit Number 1 as well. So my point is that he scored in the normal rage of the validity scale, so we can trust the rest of the profile, and the rest of the profile is quite clear: he scores a peak on the hypochondriasis scale.
O. I remind you. Doctor, when you express any opinions they must be to a reasonable degree of psychological certainty
A. Yes.
Q. And have all your opinions and conclusions you've given us so far been to a reasonable degree of psychological certainty?

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A. Yes. they certainly have.
Q. The Defendant's Exhibit 2. the second heading under "lie" is "fake bad"
A. Right.
O. As I recall from Dr. Copple's testimony he disagreed that that was a proper tern to use. Have you reviewed Dr. Copple s testimony?
A. Yes. I have.
O. Would you agree with that portion of his testimony?
A. No.
O. Would you explain to us why not.
A. Well, the books that I talked about earlier, the atlases of profile, routinely refer to the second scale as a "fake bad' scale, or they will say that the scale detects faking bad. It's in the literature all over the place.
Q. Sa the term 'fake bad" is not your term?
A. No.
Q. It's something that you receive from the atlases or the manuals that you described?
A. Correct. Yes. Yes.
O. Now, have you given us all your conclusions or all *the findings from the MMPI that were administered*

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both by you and Dr. Copple?
A. Well, let me just emphasize that both Dr. Copple and myself found profiles where the peak was hypochondriasis. There is one more - really *two* more points worth making, and they are that this shows that his primary problem is not depression; the Beck Depression Inventory had confirmed that already. His primary problem is this hypochondriacal problem.
The second point that's very important is that this, indeed, is a valid scale of a psychological problem called hypochondriasis or somatoform pain disorder. Obviously this scale is not a scale that detects real physical illnesses. Obviously the constructors of this scale were very concerned about this scale not being a measure of real physical illnesses but, in fact, being a measure of hypochondriacal problems, and so soon after the Scale was constructed researchers went into hospitals and found people who were really physically ill and gave them the MMPI, and they found that these really physically ill people scared normally on the hypochondriasis scale. The notion that some people have, the notion that when you get more and more physically ill you look more and more hypochondriacal on that scale is quite naive. The test constructors weren't so foolish as

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to make a test scale, call it hypochondriasis, but then turn around and have the scale go up when the person is really physically ill. That would be a terrible scale.
O. Do I understand hypochondriasis as that term is used in the MMPI and as it appears on Exhibit 2, a n I correct that it does no! measure real physical pain?
A. Correct
O. What does it specifically measure?
A. The exaggeration of physical pain or the confabulation of physical pain, the taking of physical pain.
Q. You tell us then, What is the significance of both your test results and the test results by Dr. Copple?
A. Yeah. To a reasonable degree of psychological certainty this is the profile of a person with a hypochondriacal problem, a mental problem; it is consistent with normal medical tests, a wide range of unusual complaints like blackouts; it is consistent with a person who at the time of the accident acted normally and yet later claims that it was a disabling injury. It's consistent with all of that.
O Did you reach a diagnosis?
A. Yes, partially based on this profile but

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also partially based on my other profile, which is the Personality Assessment Inventory that, as you will notice, is valid.
Q. Before you explain the results, why don't you explain to the Court what the personality profile - is that the correct terminology?
A. Personality Assessment Inventory.
Q. And those results are reflected in Exhibit 1?
A. Correct.
Q. Would you explain to the Court first what that test is.
A. It's very much like the MMPI in that it is a subjective - it is one that forces the - in this case, Mr. Byrom, it forced him to make marks with a pencil in certain pigeon holes. It's easy to count up his marks; it's easy to put them on the scale form and to come up with scale elevations or scale scores. That's all objective. Then, once again, the profile can be compared with the profiles of other people in order to generate a very objective interpretation of the profile. And in this case Mr. Byrom scored a peak, really one and only one peak among the clinical scales; it's called somatic complaints. His peak was on the somatic complaints scale. And -

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Q. Could you explain to the Court what that is or what is the significance of that?
A. It's basically the same result as both of his other MMPIs, as a person with a hypochondriacal tendency to exaggeration of physical pain in order to escape from stress.
Q. Would you then explain to the Court what is specifically your diagnosis of Mr. Byrom remembering again you must express it to a reasonable degree of psychological certainty.
A. My diagnosis was a hypochondriacal disorder called somatoform pain disorder.
Q. Doctor, that term that you just used. you'll have to help me again with what it was.
A. Somatoform pain disorder.
Q. Where does that tern come from, Doctor? Is that a tern that you made up?
A. No. No. It comes from the Diagnostic and Statistical Manual, the third edition of that manual, and the revision of that edition.
Q. Could you explain to the Court, is that commonly referred to as the DSM?
A. It's the DSM-III-R.
Q. Could you explain to us what that is.

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A. At the time of the examination it was the manual the premier manual of psychological diagnosis. It is used by virtually all psychologists and psychiatrists to diagnose people. It is required because, of course, to diagnose something you have to have the thing that you diagnose be a recognized mental health problem, and the DSM-III-R is accepted the world over as the definitive list of diagnoses.
Q. Is there an agency or group that officials, sanctions or recognizes mental disorders?
A. Yes, virtually all psychological organizations and agencies recognize it. It was produced by the American Psychiatric Association.
Q. You mentioned, you said - I think your words were that at the time of the exam.
A. Yes.
Q. Is that now a d i d source to use?
A. Well, the next edition of the manual has come out. and that's called DSM-IV, and so - but that only came out about two months ago.
Q. Did the DSM-IV change significantly from the DSM-III in terns of the problem that Mr. Byrom has?
A. No. It's a slightly new set of words to describe the same problem. They used to call it

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somatdorm pain disorder. now they simply call it pain disorder. The term somatoform was proliferous.
Q. What, again, was your diagnosis, Doctor?
A. Somatoform pain disorder.
Q. Will you explain to the Court what that is.
A. Yes. It is, as I say in my report. a problem of exaggeration of physical ills for the purpose of getting out of work. The person usually after a minor trauma, either at work or on the highway, the victim will begin to claim that the trauma caused him to became disabled and ill and specifically that the trauma caused the victim to feel pain, physical pain. By virtue of those pain complaints the person receives all kinds of rewards; he gets to escape from the stress, he gets to quit working. he gets sympathy from his family members. he gets drugs. Pain killers can be a great relief from mental suffering and from stress. So they essentially get pain pills, and so the process feeds on itself with the person continuing to complain of physical ills, getting rewards because he complains, and therefore intensifying his physical complaints.
Q. Doctor, do you have an opinion - and once again, to a reasonable degree of psychological certainty - as to the cause of Mr. Byrom's disorder?

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First, do you have a cause opinion?
A. Yes.
Q. What is that opinion?
A. To a reasonable degree of psychological certainty it was caused by his Stressors across his life, particularly the foundation laid by his slightly abusive slave-driving father. His father iorced him to work really unconscionable hours when he was growing up. Again, I repeat at age six he was working 11 hours a day when he was off school. four hours a day when he was on school seven days a week. That's a lot of hard work. That sets a child up for, one, he wants to escape from the work, but he's a afraid of his father and father figures, so he's afraid to simply retuse, to say, I'm not going to work. He's afraid to do that because he's afraid he'll get hurt or punished. So the solution is to claim that you're too sick to work.
Q. And the stresses that you indicated are those that you have previously testified to and were listed on Defendant's Exhibit 3?
A. Right And then lo and behold much later in his life he was showered with stressors, any one of which I think was more stressful than this accident, but the accident was the thing that allowed him to get rewards for

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claiming pain; the others he couldn't-milk
Q. Doctor -
MR. SCOTT: I'm going to move tu strike that as being totally inappropriate and editorial.
Q. Well, when you say milk, what do you mean by that, Doctor?
A. Yeah, it is a, I think, a quite legitimate term used to describe a process of somatoform pain disorders. I don't mean to imply that he Is doing this consciously, that he is laughing at us and fooling us consciously. He's fooling himself. And in the sense that the person can fool themselves and talk himself into taking advantage of a situation, I would call that milking the situation. And I think that the dictionary will bear me out on the use of that term: I don't think A's entirety pejorative.
Q. Doctor, did you reach a conclusion - again, to a reasonable degree of psychological certainty - as to a prognosis for Mr. Byrom?
A. Yes.
Q. And would you tell us what that prognosis is, please.
A. If he aets the rioht treatment. his

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prognosis is good. He's been through hypnosis for the purpose of getting rid of his depression or something; that strikes me as a rather unusual treatment. Instead, the typical treatments for a person who exaggerates pain is an emotionally oriented treatment called client-centered therapy. It's purpose is to make him a little bit more aware of what he's doing to himself and make him more aware of the fact that he is under a lot of stress and that this is not the way to deal with it. And then follow-up to that is a change in focus to what's called reality therapy, and that's an approach that basically urges him to find a new solution to his stress, one that's not quite so indirect or manipulative.

Q. *Doctor, are you familiar with the Wide Range Achievement Test?*

A. Yes.

Q. *Is that commonly referred to as the WRAT-R?*

A. Yes.

Q. *Would you please explain to the Court what the Wide Range Achievement Test is.*

A. It is an achievement test, meaning an academic achievement test, and its purpose is to measure the extent to which a person has learned his lessons in school.

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Q. *Does the test measure possible brain damage?*

A. No. While it may correlate with brain damage, and obviously if a person were severely brain damaged I suppose that he wouldn't be able to perform on this test, it is by no means regarded as a test of brain damage. It's an achievement test.

Q. *Doctor, when you examined Mr. Byrom and tested him, how long was he here or at your office at that time?*

A. He was with me all day, roughty seven hours or so, eight hours.

Q. *Can you tell us how much of that time was in testing and how much time was in actually interviewing with you?*

A. As I recall, it took him about an hour and 40 minutes to complete just the MMPI. That's not unusual. Some people in his - mentally ill people take longer. But remember, he had already taken the test once. so I suppose that he had become a little more speedy at it, so it took him about an hour and 40 minutes just to do the MMPI. It took him another hour to do the Personality Assessment Inventory. Then filling out our forms probabty took him another hour or so. And then I interviewed him the rest of the time.

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Q. *As I recall from Dr. Copple's testimony I believe Mr. Byrom spent 2 total of two hours with him. I believe his testimony was an hour and ten minutes in testing and 50 minutes in - I think he used the term "history taking." In your experience and opinion as a psychologist is that an adequate amount of time to express valid results?*

MR. SCOTT: Objection

A. There are -

MR. BORELL: Let's put the objection on the record.

MR. SCOTT: He has no basis for making that assumption, which is what it's going to be.

Q. *Answer that based on your experience and training.*

A. I think just to clarify, you're asking me whether or not I have any reaction - whether I have any knowledge of how long it takes to psychologically examine somebody?

Q. *Based on your training and experience*

A. I think that I do have an opinion about that. it's really a two-part opinion the first part is that it would be very unusual for him to - for Mr. Byrom

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to be able to complete his first attempt to take the MMPI - it would be very unusual for him to be able to do that in an hour and ten minutes; that would surprise me greatly.

The second thing is that a 50-minute interview is - while it is typical for a patient who is promising to come back for ongoing treatment; it is, I think, very short when one is trying to decide a sensitive contested legal issue about the presence or absence of mental illness More and after an accident. It's an inadequate amount of time to investigate a *contested* issue like that.

MR. SCOTT: I'm going to move to strike the answer as being nonresponsive to the original question.

Q. *Doctor, you've also testified that you reviewed numerous records from other sources.*

A. Right.

Q. *All the records you reviewed, are those records customarily the kind of records that psychologists use in the practice of psychology?*

A. Yes.

Q. *Doctor, you expressed numerous opinions and conclusions today. Were they all to a reasonable degree*

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of psychological certainty?

A. They were.

MR. BORELL: Thank you, Doctor; that's all I have.

MR. SCOTT: Doctor, my name is Robert Scott; I represent Mr. Byrom. I'm going to be asking you a number of questions today.

- - -

CROSS-EXAMINATION

BY MR. SCOTT:

Q. *First of all, you are not an orthopedic surgeon, are you, sir?*

A. That's correct.

Q. *And you are not professing any expertise today in that area of medicine, are you?*

A. That's correct.

Q. *You are not a physician, in fact, are you, sir?*

A. That's correct.

Q. *And you have no medical training?*

A. That's no formal medical training to become a physician, you're correct.

Q. *You stated, jeez, if not once maybe three or*

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four times in your direct examination that you would be remiss if you did no?pay attention to the medical records and particularly opinions of medical doctors.

A. correct.

Q. *Are you aware of what the opinion of Dr. Simon is in this case?*

A. Let me look.

Q. *Have you reviewed his testimony in this* case?

A. I don't think that I've reviewed his testimony, no; what I have reviewed are some of his records.

Q. *Would knowing his opinions with regard to Mr. Byrom's physical injuries be important to you?*

A. Not onty would it be important to me, but I have cited his opinions about Mr. Byrom in my report.

Q. *Well, you believe that you can get all of Dr.* Simon's *opinions simply from reading his medical* records, *sir?*

A. The question of whether I can get all of someone's opinions in any way is really a very difficult one to answer.

Q. *So would it be -*

A. I'd have to say. No, that I can't get all of

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someone's opinions really in any way.
O. Other than listening or reading their testimony on that subject, correct, sir?
A. I don't mean to quibble. but to claim that you now have all of someone's opinions is a rather bold statement to make. There's always something more that a person could say, and that's what I mean.
O. Isn't it equally as bold to come to opinions based on assumptions arid reading between the lines from a medical doctor's records?
A. I don't think that's an accurate characterization of what I did. I think my activities were much more straightforward than that. I simply read his notes and his letters on this case.
O. Are you trying to tell us in this case that Mr. Byrom was not injured in this cmsh?
A. That appears to be the case according to several physicians' tests, yes.
Q. Wait a minute. According to several physicians' tests; you're now interpreting medical tests to come to your opinion. sir?
A. No. No. I'm simply saying that physicians have reported normal medical tests.
O. In all respects with regard to Mr. Eyrom?

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A. Yeah; I saw no evidence of tests showing any physical disorder.
O. Sir, do you know what is entailed in an orthopedic examination of a patient?
A. No.
O. What medical tests are you talking about other than I think you referred to an x-my and an MRI?
A. RigM. Yeah. A normal x-ray, a normal spine MRI and a normal neurological exam.
O. Well, what do these physicians report concerning limited range of motion for Mr. Byrom?
A. They report that he shows a limited range of motion.
Q. Do you know what diagnostic test they performed upon him to reach that opinion?
A. No, I don't.
O. So it would no: be fair to say that all his medical tests ae normal then, are they?
A. Well, if you want to define, for example, grasping someone's arm and rotating it and having him not rotate his arm fully, if you want to call that a medical test, then of course I'd have to shift my answer, but I sort of regard that as an informal procedure.
Q. What did the orthopedic surgeons call them,

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Sir?
A. I don? know.
O. Do they not have specific names for some of these tests?
A. I believe that they have specific names for some bodily manipulations, yeah.
O. What about muscle spasm; what do the recoids show as to muscle spasm?
A. Well, there was one person named Hatfield who, I think, is a physical therapist who reported muscle spasm in July of 1989.
O. Well, in fact, isn't it true, Doctor, that Mr. Byrom received an injection at a trigger point for muscle spasm specifically?
A. I believe he received an injection; I don't recall whether it was for muscle spasm or not.
Q. Do you know if muscle spasm can be faked?
A. I don't know.
Q. Do you know if muscle spasm is associated with pain?
A. Yes, it is associated with reports of pain.
Q. So if, in fact, muscle spasm was objectively found on Mr. Byrom and. in fact, he had an injection at a bigger point for muscle spasm that would no! necessarily

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be a normal medical finding. would it?
A. Well, again, you seem to be asking me to give you a medical opinion now.
Q. No, I'm asking you if the basis of your psychological opinion is that all the medical tests were normal. I'm simply trying to point out to you, in fact, you're making an invalid assumption.
A. I guess I stand ready to see the document that reports an abnormal medical test; it's as simple as that. I haven't seen such a document.
Q. Are you aware of Or. Simon's testimony in this case that Mr. Byrom was. in fact, injured in this vehicular collision In April of 1989?
A. That sounds familiar.
O. Are you aware that. in fact. Dr. Simon stated in his testimony that Mr. Byrom improved mildiy over what amounted to a three-year time?
MR. BORELL: Objection. i don't think that accurately characterizes Dr. Simon's testimony.
MR. SCOTT: I believe we'll find it on page 25 of Dr. Simon's deposition.
A. I'm not aware of that.
Q. Are you aware Or. Simon has diagnosed Mr.

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Byrom as having a permanent injury as a result of this vehicular collision?
A. No: i am not aware of that. I am aware of many of the things that he wrote, however.
O. Are you aware oi the fact that Dr. Simon's opinion in this case is that Mr. Byrom can no longer drive a truck for a living due to his injuries?
A. That sounds familiar.
Q. Are you aware - and you spoke about this on direct examination, disability. Do you have any idea as to how an orthopedic surgeon or medicai doctor arrives at a rating of disability?
A. I have some idea, yeah.
C. And, in fact, I think in your direct examination you made mention of the fact that in your opinion - and I think you're making an invalid assumption again, but in your opinion Mr Byrom was ten percent disabled as a result of his Korean War gunshot wound, but only six percent at the time Dr. Simon saw him.
A. That is my testimony.
O. And you believe that's accurate?
A. Yes.
O. Tell me, what is your understanding as to how an orthopedic surgeon would arrive at a disability

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rating for a particular injury?
A. Again, I want to remind you that earlier you asked me if I had any idea how they come to a disability rating, and my answer is, Yes, I have some idea.
O. Well, tell us your idea.
A. I believe that the process is somewhat subjective. The physician examines the person's various body parts and functions and comes to a conclusion as to what body part - what role a body part plays In the overall functioning of the person and uses that to come to. some general estimate of the person's percentage of disability. tt's not scientific; it's fairly subjective, although the rating itself sounds quite objective, six percent, ten percent, so on.
O. Well, Doctor, are you unaware of the fact that these folks reach their ratings of disability by using manuals and guidelines just like you?
A. Usually from the Social Security Administration; yes. I'm aware of that.
O. Are you also aware of the fact that each and every injury is treated separately and that a disability is looked a! for a particular part of the body as compared to disability oft? whole man?
MR BORELL Objection That evidence

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is not before the Court
A. I am not only aware of that. but would want to point out to the Court that Dr. Simon's disability rating was a six percent rating for the 'Whole body."
O. That's correct, as bearing on this injury
A. okay.
Q. What injury was Dr Simon speaking of?
A. I believe it was his opinion that the truck wreck caused that six percent disability; that was his opinion.
Q. But specifically he was relating that six percent disability whole man to Mr Byrom's injuries to his neck and shoulder and limited range of motion, correct?
A. That was his belief, that's correct.
O. Now, the gunshot wound that Mr. Byrom received was in his left leg?
A. Right. Correct.
O. Do you believe then or - am I missing something, or do you believe now after going through this that the gunshot wound be received in the Korean War, that injury to his left leg represented a disability for Mr. Byrom of ten percent whole body. and then separately the auto accident and the six percen! relates to his neck?

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A. Your question is? I heard what you said, but is there a question in there?
Q. Yes. I'm suggesting to you that, in fact, sir, your assumption initially is incorrect, that Mr. Byrom's disability rating didn't go down in Dr. Simon's assessment but, in fact, the six percent Simon accorded Mr. Byrom was as io his neck only and had nothing to do with his left leg.
MR. BORELL. Objection. That's not Dr. Simon's testimony.
A. Right. My impression is if Mr. Byrom had had a ten percent disability in his leg, then Dr. Simon either missed it or Mr. Byrom didn't have the ten percent disability in his leg anymore.
Q. Are you claiming Men, sir, that for Dr. Simon to put a disability rating on Mr. Byrom's injuries from this automobile accident that he would also have to rake info consideration the pncr injury to the left leg?
A. No. I suppose that he couid consistently write a report that said, I'm only going to focus on his disability with respect to the accident, and I'm going to ignore a larger disability he has from the Korean War. I suppose he could do that; it's just I'm not aware of him doing that in this report.

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Q. Well, Dr. Simon didn't treat anything for Mr. Byrom except as a result of this auto accident. his injuries as a results of this auto accident.
A. Right.
Q. So when he was asked to assess the assessment of those injuries and rate them disability-wise, why would he consider the left leg?
MFI. BORELL Objection; speculative.
A. I think the problem here is that I want to be a little more simplistic and state that we have a man here who was rated as ten percent disabled during the Korean War; I think we can agree on that. He was rated as six percent disabled after this accident. I find that important. I don't - I can't really speak to the internal goings on with Dr. Simon: I don't know how he reached his conclusion or why he may not have ekher been aware of or chosen to focus on the Korean Injury. I don't know that.
Q. Sc if I understand you correctly, you think that more appropriately Dr. Simon should have taken the ten percent disability for which he had no treatment of Mr. Byrom and then add to that then and come up with 75 percent jus! to make it better for you?
A. No. I also don't want to speculate about

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what Dr. Simon should have done; I don't have any advice for him; he's in a different field than I. I'm simply trying to take all of the medical opinions Into account.
O. Is the answer to my question that you don't really know and that you were just assuming when Dr. Simon came to a six percent disability fating that Mr. Byrom somehow had gone from ten percent down to six?
A. No. I don't think you're correctly reflecting my opinions here.
O. Well, that's what your report states, and that's what you testified to on direct.
A. I don't agree that my report states that or that I've testified to that.
Q. Well, let's read it
A. Okay. Go ahead.
O. You say in the last paragrapn under "Physically disabled before accident. Mr. Byrom's experience in Korea was the most stressful time in his life. While there, enemy gunner shot him in the left leg. Later physician said he was ten percent disabled"
MR. BORELL: Which Page are you on?
MR. SCOTT: On 2.
A. Okay. You read my report correctly. That last sentence ends with that 'We received a pension for

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this."
Q. That's correct.
A. Again, More the accident.
O. Now let's go to after the accident.
A. Ali right.
Q. Find the sentence where you comment upon the six percent.
A. It's in the table labeled "Mr. Byrom's diagnosis after the accident."
O. I found it I found it. Summary, first page; it was on the wrong page. Why don't you just read it for us.
A. Okay: Decades before his -
O. No, read the summary, first page.
A. Oh, start at the beginning of the summary?
O. It's one short paragraph long. sir. I don't know where you're looking a! but -
A. I was reading -
O. It's in your report, is it no? In fact, you have it highlighted.
A. Right Okay, I was beginning to read the second sentence in the summary, but if you like I can read the entire summary.
Q. Yeah, why don't we get the whole thing in

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there.
A. "Summary. Mr. Byrom endured hard work and many other stressors. Decades before his 4/89 accident he was rated as ten percent disabled. Then after the 4/89 accident he complained of pain, but medical tests showed no injuries, and his disability rating dropped to six percent. Meanwhile mental tests" -
O. To be fair, you have that portion, "Disabilfy rating dropped to six percent,' highlighted in vour report, correct?
A. k correct
MR BORELL: It's not highlighted; it's highlighted in his copy.
Mfi. SCOT: That's what I'm talking about. His highlighting is what's pertinent to me, and ii's highlighted in his report sitting on his lap.
Q. And you highlighted that, correct?
A. Correct. And I can just add that I think that statement is absolutely true.
Q. That, in fact -
A. In fact he was rated as ten percent disabled. then he was rated as six percent disabled.
Q. Are you saying his disability rating dropped

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from ten percent to six percent, and you believe that's accurate?
A. Absolutely.
Q. And you believe that based upon some assumption that you've gotten somewhere, that these two injuries aren't to be treated separate and distinct in terms of disability rating?
A. Right.
O. Okay.
A. Yeah. It may be that when the six percent disability of the whole body - remember, it was a rating of the whole body; it may be that the physician made a mistake and that the rating should have been 16 percent; on the other hand. the physician may have been accurate in rating his whole body disability as six percent I really am much more optimistic about the doctor and believe that his rating was accurate. that this person's whole body disability rating was six percent.
O. Doctor, isn't it true that you have no idea as to how Dr. Simon came to his disability rating?
A. Well, no, I think it's unfair to say I have no idea; I have some idea of how those things -
Q. Well, what did Dr. Simon do in coming up with the six percent?

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A. I thlnk we've already gone over that; he examined Mr. Byrom, probably put him through range of motion studies, asked him a lot of questions about his complaints and came up with this six percent rating probabty using some guidelines from the Social Security Administration, but I'm not sure about that.
Q. Well, then let's go back to the question I asked you a few minutes ago. If Dr. Simon took the cervical strain injury that Mr. Byrom suffered and used the AMA guidelines and said that cervical strain injury bears a six percen! disability as to Mr. Byrom's whole body, you believe that to be incorrect?
A. No.
O. Do you believe Dr. Simon should have gone back and added in the ten percent from the leg injury and that disability as it bears to Mr. Byrom's whale body?
A. Agaln, If you're asking me what I think Dr. Simon should have done, I just think that's beyond my level of expertise; I'm not a physician.
Q. Regardless, your assumption here is based upon your report that somehow Mr. Byrom's disability dropped from ten to six percent in Dr. Simon's eyes?
A. Right And I stand by that statement.
O. Although you have no idea how Dr. Simon

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reached his disability rating?
A. As I've mentioned several times before: it is incorrect to say I have no idea. I have read Dr. Simon's letters and reports.
Q. Do you know if Dr. Simon took inio consideration any injury to Mr. Byrom's left leg in reaching his disability?
MR. BORELL Objection. That's speculative. If there's some doubt as to what that six percent represents, those questions should have been asked of Dr. Simon.:
MR. SCOT, I can read Ml you what Dr Simon says
MR. BORELL: Go ahead and answer the question.
THE WITNESS. Could you repeat the question?
MR. SCOTT Yes.
BY MR SCOT
Q. Is it somehow your belief that when Dr Simon assesses the cervical injury of Mr Byrom that he must include every other ailment or possible disability that Mr. Byrom has in coming up with one disability rating?

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A. No. Let me explain it another way that might make it seem clearer. Let's assume that Mr. Byrom has two injuries - and again, this is an assumption that I really don't go along with, but let's assume it. He has two injuries; one is to the leg and one -
Q. Well, there's really no assumption there, is there7
A. Well, I don't know, and I'm not sure it's profitable to get off onto that. Let's just assume that he has two injuries; one to his leg and one to his cervix. Let's also assume -
O. You mean his cervical spine, not his cervix?
A. Okay, cervical spine. Let's also assume that his disability rating for his leg injury is ten percent, and that occurred during the Korean War. Years later let's assume that he had an injury to his spine and that that disablltty rating for that injury was six percent I believe that it's fair and, verbally straightforward to say that his disability injury, his level of disability caused by the first injury was ten percent; his level of disability caused by the second injury was six percent, and I'further think that it's fair to say that that constitutes a drop in disability rating.

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O. Based on what? You think it's fair based on what?
A. I think it's intuitively obvious, and I'm not sure that I can explain it any more clearly than that.
O. It's intuitively obvious?
A. Uh-huh. If I had two injuries and one cost me $100 to treat and the second injury ten years later cost me $50 to treat?it would be fair to say that there was a drop In the price of the cost of the two Injuries. And in the same way it's fair to say that a disability rating drops from one injury to another.
O. Doctor, if you were asked what it cost to treat the second injury, and that was the question put to you, why would you bother going back to the treatment that cost $100? If the question put to you is, What did that second accident, what did that second injury cost you, wouldn't you say, $50?
A. Well?it depends on the context. If the person was claiming - if the person was claiming that the second injury was somehow so monumental that it was disabling, if the person were saying that the second injury was so expensive that it caused him to go bankrupt, it might be Interesting to find out that he had spent lots more on a previous injury. Remember, we've got to keep

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all this in context. We're now quibbling about six percent! ten percent disability.
Q. I'm not quibbling about that at all.
MR. BORELL Objection. Let him finish.
MR. SCOTT: I don't think he's being real responsive to the last question at this point anyway, John, but -
MR. BORELL: Let him finish his answer, we'll ie?the Judge decide.
A. The context is that we have a six versus a ten percent disability rating. We have a person who was sometime in his past rated as ten percent disabled but he kept working: that's probably fairly normal. If you or I were ten percent disabled whole body we'd probably keep working. It sound like a low figure: it's not 50 percent. It's not 100 percent, it's ten percent. So he did, in tact?keep working. Interesting, isn't it, that when he's rated at six percent disabled he doesn't work and he claims that he's totally disabled.
O. Well, now you find that interesting, and you're not an orthopedic surgeon.
A. I'm a psychologist.
O. And Dr. Simon testified that that six

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percent injury as it relates to his whole body due to his neck ailment is sufficient to not allow him to drive a truck for a living

A. okay.

Q. Don't you have to rely on the medical opinion? I thought you told us you'd be remiss if you didn't rely on the medical opinion.

A. I've gut to rely on them all. not just one physician's. And when physicians contradict each other, I have no move -

Q. Let's talk about that right now. Do you how the difference between cervical strain, myofacial strain, cervicitis, myofascitis? Do you know what those terms mean?

A. Yes. Although they are outside my area of expertise, I generally know what they mean.

Q. Are they generally equated?

A. Well, there are - there's some discussion in the medlcal literature about that. Again, this is outside my area of expertise.

Q. That's my point.

A. Well, if you want to make the point that I'm not a physician, If you'd like to make that point again, I'm happy to concede that point.

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Q. Well, if you're not an orthopedic surgeon, and you haven't read the testimony of Dr. Simon and his opinions in this case, and you're not familiar enough with these terms to tell us whether they're equatable or not, how can you say they don't equate?

A. A tew points; first -

Q. Well, answer my question first, then you can make whatever points you want.

A. I am somewhat aware of the terms that are being used: I've mentioned that It's unfair -

Q. Well, in fact, turn around to your exhibit, and let's look at it.

A. I'd like to finish my answer.

Q. Okay. I'll turn it around while you finish your answer.

A. I am somewhat familiar with the medical terms at issue in this case; I am familiar enough with the terms to know which are different and which are similar. The records show that the physicians are not in agreement about me physical problems in this case. What I am being asked over and over now in this cross-examination Is to focus on one physician's opinions and to somehow take that at face value while Ignoring, lor example, the negative medical tests. So that's our problem.

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Q. Well, you already admitted that some of the medical tests weren't. in fact, normal or negative.

A. No, I have not conceded that,

Q. Oh, you believe -

A. I've invited you to produce documents.

Q. Why don't you pull out Dr. Simon's, Dr. Rogers' medical reports and tell me what they say about their testing in terms of limited range of motion for Mr. Byrom.

A Okay. Let's just look those up. Okay. I'm looking here at the x-ray of the cervical spine; and, of course, as I mentioned, It's normal. I'm simpty looking for some evidence of some test that is - that is abnormal. Agaln, what we're discussing now is whether or not any medical tests show an abnormal functioning or abnormal results? Here's an attending physician's reports that says the x-ray diagnosis is within normal limits. I feel a little odd looking for something that I don't think exists, but I will do my best.

Q. You believe that Dr. Simon never made reference to muscle spasm or limited range of motion in his notes7

A. That is not my testimony, obviously. My testimony and what we are focusing on right now is whether or not there are any medical tests that are abnormal; that's what we're doing.

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Q. Well, how do you think that Dr Simon gets to an opinion about range of motion without ,performing a test?

A. Well, I'm not sure about what goes on in Dr. Simon's head; I do have to ask, Are we now moving away from the question about whether there are negative medical tests or not because I'm continuing to assert that the medical tests are normally.

Q. I'm still trying to get an answer to that question.

A. You're looking over the records yourself. I assume you're also searching for a positive medlcal test.

Q. No, they're here. I'm asking you to find me one where he has said range of motion is normal.

A. Okay. But agaln, range of motion is normal; I can only repeat I thought that the topic that we're now proceeding with is whether or nut h t has any positive medical tests.

Q. You don't believe that a limitation in range of motion for a cervical spine injury is not a positive physical finding?

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A. Is your word "positive physical finding," or is your word 'test."

Q. Look, Doctor. we've already wen! through this: orthopedic surgeons test people with injuries using numerous types of tests; they have names; you've conceded that. That's how they test range of motion; that's how they test for muscle spasm; that's how they find trigger points for muscle spasm.

A. Uh-huh.

Q. Now, Dr. Simon has repeatedly reported range of motion for Mr. Byrom as not normal.

A. Okay.

Q. He didn't just make that up; he performed a test, and those were his findings.

A. I'm simply saying I have seen no such tests.

C. Why don't you look at -

A. You want me to find what you assert exists? I'm afraid I can't do that Go ahead and show me.

Q. Didn't you rely on these records? I thought you would be remiss in not looking at these records 2nd taking the doctors' opinions -

A. Let me make sure what I understand we're doing now. You want me to find what you assert exists and what I assert does not exist? It's my responsibility to

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find your evidence?

C. Doctor, I think what you're doing now is you're beating around the bush.

MR. BORELL If there's something you want to show him, why don't you show it to him.

A. Let me --

MR. BORELL: Doctor, we've spent a lot of time on beating a dead horse. Why don't you just show him what you've got, then we can get on with it.

BY MR. SCOTT:

Q. Look at the first date, April 10th, physical exam.

A. The first date, April 10th.

Q. I assume you're looking at Dr. Simon's records, and I assume you can find the first date of examination?

A. What is the date of that particular record?

Q. April 10th.

A. Of 1989?

Q. Yes.

A. All right. Hang on. Got it.

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Q. Do you see "physical exam"? Do you see where it says he cannot rotate to the right or left or lateral bend?
A. "Physical exam;" now, let's just stop right there. Are you going to - I hope you're going to ask me whether it is my sense that a physical exam is a medical test; is that what we're doing here?
Q. You don? think that the orthopedic surgeon performs testing during his physical exam of a patient?
A. Well, gee. we're getting all balled up here, aren't we?
MR. BORELL: I hope this isn't all over the word "test."
Q. I'm trying to figure out what you think goes on in an orthopedic surgeon's office when a patient walks in with complaints like Mr. Byrom. We've already discussed these tests that orthopedic surgeons do that you admit have names, that they perform this testing on patients to find things like range of motion.
A. Yeah.
Q. Now you've asked me to find a spot where range of motion is reported.
A. That's not true: you're mischaracterizing what I've asked-for.

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Q. Well, here's what I'm asking you; Does it not say, "April 10th, 1989; he cannot rotate to the right or left or lateral bend"?
A. That, it says.
Q. Okay.
A. The question is whether that's a medical test.
Q. Next we have the 19th of April, 1989; Dr. Simon actually prescribes physical therapy or is going to start physical therapy only he hasn't started at this point.
A. Okay. He's doing therapy.
Q. To reduce spasm and increase mobility, correct?
A. Where is that again?
Q. On the 19th.
A. The 19th of April, Is that -
Q. That's what it appears to me to be.
A. I guess – there you go. Okay. Cervical strain, a lot of pain.
MR. BORELL: Just so we avoid future probiems, the copy of Dr. Simon's records we have, some of the months were cut off the thing, so you may have a better mpy than we

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have. It was a problem-when I reviewed them.
A. Okay. Your point is that on April 19th indeed the physician is saying that this man is continuing to complain of pain?
Q. Well, and he obviously has decreased mobility because the doctor's going to try to increase it, isn't he?
A. Yes. Yes. What that means is -
Q. Well, wait a minute. What it means is whatever Dr. Simon means.
A. Yeah, I completely agree with that. I'm still looking for a medical test, but go ahead.
Q. You don7 know - is it fair to say you don't know what testing Dr. Simon did to check range of motion or mobility of h e neck?
A. That would not be fair. For example, here's a statement back in the earlier April 10th note, C-spine films were done in the Manchester office, blah, blah, blah, and it says that they're normal.
Q. You think that's the only thing he did?
A. No, but what I'm saying is I think you and I and the Court will agree that that's a medical test
Q. Sure

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A. I'm just looking tor one that's abnormal; that's all. I want to continue to assert I am aware of no positive medical tests.
Q. Look down here a! the bottom of the next page, and my copy is cut off, so I can't tell you what it is
A. what date is that?
Q. There is no date, it's cut off OR my copy, so I can't tell you what date that is.
A. Does it have Elavil as the first word?
Q. Yes.
A. Yes. I got you.
Q. Now, I suppose -
A. MRI was negative.
Q. Well, let me ask you this question. You see in the middle of the paragraph where it says, "However, his flexion and his turning to the left are within normal limits"?
A. Yes.
Q. You like that; you say that's a normal finding, a normal test result?
A. No, I would not characterize that as a test. To say that his flexion and turning to the left are within normal limits, I wouldn't call that a test.

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Q. Well, how does the orthopedic surgeon test that then? I mean, how does he state that?
A. I think the patient tells him. 1think the patient comes in and tells him, I'm having trouble moving.
Q. So Vat's your assumption?
A. Yes, and that's an assumption.
Q. It certainly is.
A. On the other hand there -
Q. You've answered my question. I've got you, You say you've assumed. I understand what you're saying now. You assume that that's just the patient telling the doctor that, Yeah. my neck won't tum, correct?
A. Yeah.
Q. Okay.
(A discussion was had off the record.)
Q. What age was Mr. Byrom when this crash occurred?
A. Let me look. I think he was in his - let me look.
A. He was born in 1932; his accident was in 1989, and so by sheer subtraction I come up with his being 57 years old. The reason I'm a little confused about that is that he was described by some of the physicians 2s being 53, but it looks like he was 57.

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Q. Okay. And throughout his life up to the time of this crash wouldn't you say that his employment history was good?
A. I think it was adequate. He had five jobs over the lifetime of his career. That's fine.
Q. In fact more importantly he was continuously essentially employed from the time he left Korea until the time of this crash, correct?
A. Yes, I believe that's true.
Q. Those stressors you talked about, how many of them pre-date this auto accident?
A. Well, they surround the accident.
Q. I'm asking for the ones that pre-date.
A. Okay. The marital separation was, I believe, before the accident.
Q. When? How long before?
A. Several months. The Jobloss and the new job predated the accident
Q. Well, in fact, there was no job loss. Didn't Mr. Byrom simply change jobs because he wanted a shorter route?
A. Okay.
Q. He wasn't fired or terminated?
A. I didn't sav he was fired or terminated.

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Q. He didn't lose a job; what he did was change jobs?
A. Okay. We can call it a job change; he left one job and started another.
Q. And that was *before the accident7*
A. Right. So that would be two stressors. His emphysema, though diagnosed. I think, after the accident was obviously - it's obviously a chronic condition that existed before.
Q. *The broken ankle* was *after, correct?*
A. Correct
Q. *Now, when* was *Mr. Byrom referred* by *Dr. Simon lor this first time for psychological help?*
A. I am not sure when the referral was made. I just am not sure, but I do know that it was months after the accident in November of '89 that Mr. Byrom first wanted a psychiatrist because of what he called depression.
Q. *So you don't know when Mr. Byrom first saw a psychiatrist in relation to some of those stressors that occur after ?he accident?*
A. Well, I think that I can dig that *out.* Hang on. I have him in treatment in November of 1989. Yeah. So it looks like he got treatment roughly seven months

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after the accident, probably when most of the stressors had taken place and were taking place.
Q. *Well, when* was *the diagnosis of emphysema made?*
A. November of 1989.
Q. *Before or after the psychological help?*
A. It looked like it would be pretty much concurrent with it. Maybe I should rephrase that; *that* is the time when it was noted; I just don't recall exactly when the emphysema diagnosis was made other than it was made sometime in the months after the accident. I just don't recall.
Q. *Doctor, how much do you charge for these evaluations?*
A. $100 an hour for interviewing and report writing, $40 an hour for records reviewed.
Q. So how *much have you charged Mr Borell so far in this case up to today?*
A. I just don't know, but my guess is that it's about $1,000 or so.
Q. You have *no standard charge for a report?*
A. Well, I just described it, it's on an hourly basis.
Q. How *much of your income is derived from*

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evaluations for attorneys?
A. I'd say about an eighth or *so.*
Q. *An eighth?*
A. Uh-huh. This takes into account the fact that I'm a university professor, full-time tenured university professor.
Q. *You think an eighth of your income comes from the evaluation of claims such as this?*
A. Right That's of my total income, that's right.
Q. Was *A ever larger than that?*
A. No.
Q. *Okay. Doctor, do you claim in this case that Mr. Byrom does not suffer ana has never suffered from depression?*
A. Right. That seems to be clear based on testing done by other psychologists and based *on* my own testing, for example.
Q. *Well, another psychiatrist in this case did diagnose depression* for *Mr Byrom after this crash didn't he?*
A. Yes.
MR BORELL Objection Whose mats *true* Mickey, *that* doctor did not cause it

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related to this accident Your statement is not incorrect. it's just incomplete
MR SCOTT Oh, no, I simply asked this doctor is it his opinion Mr Byrom does not *and has never* suffered from *depression.* And *the answer* was. That's correct, I don't *believe he* ever has
Q. *Right?*
A. That's correct.
MR. BORELL: My objection is not to his answer but to *h e* way you characterized *the* question Your statement *was* true; I would *only* object it was *incomplete in* that you left out the lack of causal connection. But let's *move* on.
MR. SCOT: Okay. I'm not sure I understand that, but okay
BY MR. SCOTT:
Q. *But, Doctor, you described Mr. Byrom as slightly depressed on your examination of him.*
A. Well, you'll have to show me where that is.
Q. *Sure. Look ai footnote 47.*
A. Okay. Let's see what the *context* of *that* footnote is.

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Okay. That footnote number 47 is a description of some of the features of people whose score peaks on what's called the low back pain scale. In other words, that footnote relates to his score on one obscure scale in the MMPI; that scale is the low back pain scale, which is a kind of hypochondriacal indicator. The footnote-
Q. *Well, let's read ?hefootnote.*
A. Okay. Well, let me just finish my answer. What that footnote is saying is that the primary problem with this guy is a hypochondriacal exaggeration of back pain. In addition to that, it's not unusual for people with hypochondriacal problems to complain of depression. They're wrong to diagnose themselves as depressed, but they do complain of depression.
Q. *Doctor, footnote 47, the firs?sentence (in reads - and his is you talking, right? This is your footnote?*
A. No, that is not correct
Q. *a:) "Mr. Byrom seems restless and slightly depressed but denies geting angry and rarely expresses an opinion.'*
A. A is not correct to say that those are my words; it is more correct to say that this is *what* the

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book says is associated with that particular scale.
Q. *Wait 2 minute: this is what the Sook says, Mr. Byrom -*
A. Yeah.
Q. *- is like?*
A. No, it doesn't use the word Mr. Byrom.
Q. *Well, you used that word then, correct?*
A. Right
Q. *You used "Mr. Byrom -*
A. RigM
Q. *- seems restless and slightly depressed but denies getting angry and rarely expresss an opinion"? You wrote that?*
A. Yeah, but I got it from the book that describes that particular scale. The overriding point is that I don't deny that Mr. Byrom complains of depression; he told me during the Interview that he was depressed a month ago or years ago. The problem is that hypochondriacs often report depression.
Q. *Well, you wrote that.*
A. They're not depressed. but they report it.
Q. You wrote. *Doctor, "Mr Byrom seems restless and slightly depressed "*
A. Yeah, and I stand by that: he seems that

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way. That's a far cry from being that way or from having the diagnosis of depression.
Q. Isn't it a far cry from how you descnbed him earlier?
A. No.
Q. You descnbed him as very happy, laughed at your jokes, whatever.
A. Right.
Q. Then in footnote 47 you tell us he seems restless 2nd slightly depressed.
A. Right. But as I told you, that footnote relates to his score on one subscale of the MMPI; that's clear if you have the report in front of you. The footnote -
Q. It's not clear. You write "Mr. Byrom seems restless and slightly depressed but denies getting angry and rarely expresss an opinion." Now, did you get that fromhim, or did you ge! that in a combination from asking him questions and observing him?
A. Maybe the answer to that question would be made clearer it we just read on on the footnote. If we continue to read on the footnote it says, "Often Mr. Byrom trles to cover up lnadequacles and lnsecurltles." Then I put, "An MMPI expert summarlzed that, 'a high low-back

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pain score suggests psychologicalfactors may be preeminent in reported low back pain.'"
Q. I understand all that.
A. okay.
Q. Explain to me why you wrote "Mr. Byrom seems restless and slightly depressed but denies getting angry and rarely expresss an opinion." You wrote that?
A. You are correct that I wrote that. I took it from a book that describes his scale score on one obscure scale on the MMPI. The report makes that clear.
Q. Well, why would you write that Mr. Byrom seems restless and slightly depressed if you didn't feel that was true?
A. Because I did feel that it was true. But it's a tar cry from diagnosing depression to say that someone seems slightly depressed. That's not a diagnosis of depression.
Q. NO! only is it not a diagncsls, I guess, but it's wholly contradictory from what you've written earlier.
A. The Court will have to decide it I described some person as seeming slightly depressed, the Court will have to decide whether that is tantamount to diagnosing them with a mental illness of depression.

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Q. Let's look at your MMPI scale.
A. Okay.
Q. Go to that graph where you have both yours and Dr. Copple's.
A. Okay. I've got it right here.
Q. Results. You're now looking at if? I see in both instances a score on depression greater than normal range.
A. True.
Q. You scored Mr. Byrom greater than normal range on depression as well as Dr. Copple, correct?
A. That's correct. And there's one scale higher than those, and that is hypochondriasis.
Q. How many cases this year, let's say this past year, a year from today back, have you reviewed? Legal claims like this.
A. During the year 1994, maybe eight. No, maybe ten, 15, something like that.
Q. How many of them have Seen personal injuries like this? Is that the eight or ten you're talking about?
A. Most of them, say - let's settle on the figure of 12, then I'll say that maybe seven of those are personal injury cases.
Q. Of those seven, how many were you hired by

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the defense?
A. Of the seven?prokabty five defense and two plaintiffs.
Q. Of the five defense cases, on how many did you reach a diagnosis of somatoform pain disorder or pain disorder?
A. I don't really know. You're now asking for a highty specific set of information. I can say this, that 1 probably diagnosed it in least some of the - I mean, I diagnose that fairly frequently, and the reason is that often in litigation the whole issue is whether or not the person is being hypochondriacal. That's really the dispute. So the number of people that have hypochondriacaldisorders in the population of litigants Is really quite high.
Q. Let me ask you another question about the evaluation tha! you did. Are you claiming, jus! so I understand it correctly, that Mr. Byrom suffers from some psychological disorder that you call somatoform pain disorder?
A. Correct. Well, I don't call it that, the DSM calls it that.
Q. But you've called it that for us today; that's your diagnosis?

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A. It is my diagnosis drawn from the manual, that's right.
Q. And you believe that the cause of that condition is Mr. Byrom's childhood?
A. Yes, and his stressors surrounding this accident.
Q. Obviously ?he accident is one of those stressors?
A. Well, I don't know that that's obvious. We have a man who was in an accident, got out of his truck, looked around for the driver, changed his clothes, drove. At worst it was a minor stressor.
Q. Well, you listed it as a stressor.
A. Well, I have said over and over that even assuming that he really was injured, it's not much of a stressor. And as I've said before, that's a dubious assumption.
Q. Well, let's think about that for a second. First of all, you've got a fellow who's on a new job, right?
A. Uh-huh.
Q. Somebody crashes into his company's truck.
A. Okay.
C. Is that a stressor?

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A. Yes, it's somewhat stressful.
Q. He gc! hurt.
A. That's a dubious assumption.
Q. That's Dr. Simon's opinion, he got hurt
A. Okay.
Q. I thought we would be remiss if we didn't take into consideration the medical doctors' opinions.
A. That is correct; we would be remiss it we focused on one physician's opinion and ignored the medical tests, for example, and ignored the other opinions. We would be remiss if we did not do that
Q. What medical doctor ever said Mr. Byron wasn't hurt in this accident?
A. Well, while it is difficult to answer that question because I suppose you'll ask me to come up with a "medical test" showing no injuries, and so that would be an example of a physician's failure to find an injury.
Q. Eo you know what a so! tissue injury is?
A. Yes.
Q. Do you know tha!, for example, an x-ray will no! show a so:! tissue injury?
A. Yes.
Q. Do you know tha! orthopedic surgeons will routinely say, It is of no significance to me that this

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x-ray is normal with this soft tissue injury that the fellow has?
MR BORELL Let me object, but go ahead and answer it.
A. Again, we're a little bit outside my area of expertise, but yes, I am aware that soft tissue injuries don't show up on x-rays.
Q. You are aware that Mr. Byrom was diagnosed with a soft tissue injury?
A. There were - yes, there were several soft tissue injuries that were diagnosed, several different kinds.
Q. So it wouldn't be surprising to you then given your experience that the x-ray test was normal?
A. Well, the - again, a little bit out of my expertise, but I concede that various physicians diagnosed varfous problems based primarily on this man's complaints of pain. I - that's my impression and statement; he told them he had paln; he told the physicians he felt pain. They, in turn, diagnosed certain soft tissue injuries.
Q. You think that they did no more than that?
A. I did not say that.
Q. Well, do you think that they did any diagnostic testing which would confirm or not confirm for

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them his relation of pain in various parts of his body?
A. The only diagnostic tests that I am aware of were negative, and you and I have worked today to try to find one that was positive, and we have been unable to do so.
Q. Well, I guess it differs depending on what you know about what an orthopedic does or doesn't do to come to an assessment of range of motion.
A. Uh-huh. If there's a question in there, my response is that this obfuscates the issue, so I'll just repeat my position, and that is there are medical tests listed in the records that you and I have in front of us; we both have medical records in front of us, and medical tests are listed; they are negative. I have seen no positive tests.
Q. And there are tests that we expect to be negative in a soft tissue injury; you've conceded that for me?
A. Right That may be true.
Q. Well, not may be true; that is true, isn't it?
A. okay.
Q. You said something on direc?examination about Mr. Byrom's acbons after this cmsh.

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A. Right
Q. Isn't it a fact that the medical records indicate and Mr. Byrom has indicated himself tha! he was, in fact, dazed for a short period of time after this incident?
A. There may be a statement to that effect somewhere in a record that has to be taken and juxtaposed alongside his behavior, which was not dazed.
Q. Well, you weren't there, correct? You didn't see this happen, right, Doctor?
A. There is a point that you and I can agree on; I was not in the truck with him at the time and don't have any inclination in that direction.
Q. Given the similarity between your results on MMPI and Dr. Copple's results on MMPI, is it no! true that Dr. Copple's finding and opinions are entirely supportable?
A. Would you ask that question again. please.
Q. Yes. Dr. Copple's findings on MMPI and yours were quite similar?
A. That is correct
Q. Is it not true that Dr. Copple's findings and opinions are. in fact, quite supportable from the record?

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A. Well, his MMPI is supportable; I believe it to be a valid and correct MMPI. I, of course, disagree with his interpretation entirety. When his MMPI shows a peak on hypochondriasis, I think his first inclination should be to diagnose a hypochondriacal disorder; it's as simple as that.
Q. Doesn't Dr. Copple go a step farther than that and testify that, in fact, by way of his testing Mr. Byrom showed elevated levels of no! only hypochondriasis but also depression and hysteria?
A. Well, two points on :hat. One is -
Q. Well, answer my question first, then you can make your point.
A. All right. The in answering your question! I'll do it with realty two points. The first point is that you are correct: he also showed an elevation on hysteria. Hysteria Is the kissing cousin of hypochondriasis. Histrionic people fake physical problems. So once again, I completely agree with the MMPI that Copple produced.
The second point is that as I've mentioned several times before, it is not unusual for hypochondriacal people to complain of depressed feelings. They feel bummed out and depressed because they believe

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they're physically ill. They're not liars. And so it does show up secondarily on some tests.
The third point worth making is that this fellow also took a test that zeroed in on depression; it's called the Beck Depression Inventory. He scored normally on that test. Again, I didn't give that test; somebody else did:'
Q. Did you hear my question, Doctor?
A. Not only did I hear it. but i think I answered it.
Q. Answer it again then. Isn't it !me that Dr. Copple's findings and his opinions are totally supported by the records, particularly the MMPI results which are strikingly similar to yours?
A. And my answer to that is that I believe that his MMPI is valid, and so his MMPI results are supported by mine. His interpretation of the MMPI and his overall conclusions about this case are not at all supported. what we have here, his own MMPI and a Beck Depression Inventory showing hypochondriasisand no depression, and yet he's not diagnosing hypochondriacalproblems and he is diagnosing depression. I'm baffled by that.
Q. So is the answer io my question you believe no -

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A. I don't believe that his valid MMPI supports his opinion. In tact. I want to go farther and say that his valid MMPI contradicts his opinion.
Q. Doctor, if in your opinion this fellow suffers from somatic pain disorder, and this is rooted and caused by his childhood, why does it iake him 57 years and this automobile accident for us to see the first manifestation of that?
A. Because as I've mentioned several times before, there are two clusters of causes; the first is his childhood which predisposed him to this problem, and then the second were a series of stressors that occurred right around this accident
Q. One of which was the accident?
A. Well, and of all of the stressors that occurred, it just seems to me that the accident pales in comparison with the other stressors at work. But we've gone round and round about the fact that in my opinion the accident was not a stressor -
Q. Well, you've hsted il as one
A. - that was significant
Well, I've said over and over, looking at it In its worst light, even if he were injured, it still wouldn't amount to much.

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Q. Well, you keep coming back to "Even if he were injured," yet you have the only testimony in this case and, in fact, you have the diagnoses listed in your report; everyone, every medical doctor who saw him after this accident felt he was injured, correct?
A. I think so. I think they diagnosed - well, they give him a physical diagnosis, that's for sure.
Q. Of an injury?
A. Some kind of problem, chronic pain or whatever.
Q. And they began treating it?
A. Yes.
Q. Now, in terms of this accident, just having the accident itself was a stressor, starting this new job. somebody crashes into the company's truck, correct?
A. Well, yeah. I mean, It's not stress-free. It's not a significant stressor.
Q. The injury is a stressor?
A. If there were an injury, that would be a stressor.
Q. The treatment in going to the doctors all the time is a stressor?
A. For him, I don't think so.
Q. The inability to work is a stressor?

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A. For him, I don't think so.
Q. Failing financial condition is a stressor; is it not?
A. That could be, yeah, as a result of not working.
Q. All those things stem from this auto accident?
A. Well -
MR. BORELL: Objection. That is not the testimony, but go ahead and answer.
A. It is not my testimony. When you - hypochondriacs don't become hypochondriacs because of an accident.
Q. Well, I thought you told us that Mr. Byrom truly believes he's injured.
A. Right
Q. That's the nature of hypochondriasis?
A. Right. Correct.
Q. And, in fact, the medical doctors in this case have testified that Mr. Byrom was injured.
A. Having not seen their testimony, you know, I don't know what to make of that statement.
Q. Well, do you want to read it?
A. I will read it. It you would like for me to.

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Q. I thought we already went through that. Were you aware Dr. Simon testified he was injured, that his injury was permanent? Certainly you know we discussed the percentage of disability.
A. Lord, yes.
Q. So Dr. Simon must obviously believe there was an injury there, doesn't he?
A. Well, you're asking me to - your question asks me, Do I accept his description or his testimony. I'm a little at a loss how to respond to that. I have not read his testimony; I'm not aware of it.
Q. Doctor, are you aware Dr. Simon felt certainty that Mr. Byrom was injured, and you're certainly aware he assessed a disability rating to that injury?
A. Yes, based on the record of him I got
Q. You used those -
A. Yes.
Q. - in part for your evaluation?
A. Yes.
Q. Correct?
A. I understand that.
Q. Are you telling us that in your opinion the hypochondriasis is something that whereby Mr. Byrom really wasn't hurt but thinks he is? .

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A. That's right. That's what hypochondriasis Is.
Q. It isn't that he may feel he's hurt worse than he really is?
A. You can also have a hypochondriacal problem -
Q. Which is it for him -
A. - following that.
Q. Which is it for him given the fact that we know the medical doctors felt he was injured?
A. It's hard to say. There is contradictory physical evidence with physicians giving different diagnoses and medical tests being normal. We've gone round and round about that. So I'm left really not entirely sure whether or not he was physically injured, and if so, what the extent was. But it's clear to me that regardless of that issue, he does have hypochondriacal problems, and that those are the primary influence on his disability now; they are big problems. Let me put it to you another way; I continue to assert that all medical tests that I'm familiar with are normal. I also want to compare that with these issues here, with these tests results here, the psychological tests, and assert that these are clearly abnormal. The testing shows a clear

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psychological problem; medical tests don't show a clear - do not show a clear physical problem. So we know he's got a psychological problem, and we know what that problem is.
Q. In fact, he's elevated in three different levels: depression, hysteria and hypochondriasis?
A. With hypochondriasis as a peak. That's true for the two MMPIs and for the Personality Assessment Inventory. His sole elevation is somatic complaints, which is a hypochondriacal scale, and keeping in mind he does not have depression.
Q. Don? you as a psychologist have to rely upon the diagnoses and opinions of the medical doctors in this case?
A. Yes. My trouble is I don't know which one to rety on. They disagree, so I'm left at a loss.
Q. Mr. Byrom has claimed essentially a neck injury with some residuals as a result of this automobile accident.
A. That is one of the things he's claiming. He's also claiming that the automobile accident caused him to begin to faint two years after the accident.
Q. You believe he's claiming that?
A. I believe so.
Q. You believe that his urological complaints

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and sexual dysfunction, You think he relates that to his automobile accident?
A. Yes. In fact, that's what he told me during -
Q. Where does it say that in any of your records?
(A brief recess was taken.)
Q. The last question was where in your - in fact you have no notes, do you, Doctor? You have this report?
A. The report is the notes. I took the information directly into the report. That's part of our new computer age.
Q. Where, anywhere in here does Mr. Byrom relate either of those two injuries we just discussed, the urological problems or the fainting problems, to this incident?
A. Remember what I said was that that's what he - he related these problems to - when he was talking with me, he related them to the accident. And so I'm not sure how to answer that question other than to say that that's what he mentioned to me.
Q. But there's no note of that anywhere here, is there?

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A. Well, at the beginning of the report I state that I got his - I got the information about his history from two Sources, and they are the documents and what he told me.
Q. But you're claiming now even though it's not in your report that you believe Mr. Byrom is relating those two problems to this accident?
A. Yeah, that was my recollection. I mean, it's not an important point; whether he did or he didn't is not important. He is complaining of blacking out two years after the accident. The complaints seem to be expanding and increasing in odd ways, which is fairly typical of a hypochondriacal problem. But As not that important whether he relates it to the accident or not.
Q. How old is Mr. Byrom now?
A. Well, having been born -
Q. Sixty-three?
A. - in 1932 -yeah, it sounds like he would be about 63. Yeah.
Q. Isn't it true that you're the only person testifying in this Case concerning Mr. Byrom's psychological condition that is going to say he's not suffered from depression?
MR. BORELL: Is that limited just to

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psychologists?
MR. SCOTT: Yes.
MR. BORELL: The two of them?
MR. SCOTT: Yeah.
A. That appears to be true, yeah, me versus some other guy.
Q. Well, actually, Dr. Craig diagnosed depression.
A. It often happens with people that have hypochondriacal problems.
Q. Well, he's a psychiatrist, right?
MR. BORELL: He's a psychiatrist.
Q. Doctor, has your license to practice psychology ever been revoked, restricted in any way?
A. No.
Q. Has the Ohio State Board of Psychology ever investigated you in your license?
A. No.
Q. Do you know if you're presently under investigation?
A. I have no such knowledge.
MR. SCOTT: Okay. That's all I have.
MR. BORELL: Doctor, when this is transcribed you have the right to review it

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and sign it. I can tell you there won't be time to do that, but you do have the right to waive it also.
MR. WITNESS: I waive.
(Deposition concluded and witness excused at 2:56 p.m.)
- - -
(Signature Waived)

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C E R T I F I C A T E

I, Tracy L. Spore, a Notary Public and Registered Professional Reporter within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, was first duly sworn to testify 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 hereunm set my hand and affixed my seal of office a; Toledo. Ohio, on this day of 1994

Tracy L. Spore
Notary Public
In and for the State of Ohio
My commission expires February 16,1998

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