IN THE COURT OF COMMON PLEAS.

CUYAHOGA COUNTY, OHIO

HERBERT C. ROSS JR,

Plaintiff,

-vs-

JUDGE CORRIGAN
CASE NO. CV-13-815257

CITY OF CLEVELAND,
et al.,

Defendants.

- - - -

Videotaped deposition of MARIAN M. CHATTERJEE, PH.D. taken as if upon examination before Chana Margareten, a Notary Public within and for the State of Ohio, at Weinstein & Associates, 24100 Chagrin Boulevard, Suite 400 Beachwood, Ohio 44122, at 3:36 p.m., on Wednesday, October 1, 2014, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff.

- - - -

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On behalf of the Defendants.



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OBJECTION INDEX





THE VIDEOGRAPHER: We are on the record.

MARIAN M. CHATTERJEE, PH.D., of lawful age, called by the Plaintiff for the purpose of examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF MARIAN M. CHATTERJEE, PH.D.

BY MR. BARBOUR:

Q. Could you tell us your name, please?

A. **Marian Chatterjee.**

Q. And what is your profession?

A. **I'm a clinical psychologist.**

Q. Are you licensed by the State of Ohio as a psychologist?

A. **Yes.**

Q. Did you see Herbert Ross as a patient?

A. **Yes.**

Q. Have you seen him multiple times as a patient?

A. **Yes, I have.**

Q. Have you evaluated him?

A. **Yes.**

Q. Have you provided psychological treatment to him?

A. **Yes.**

Q. And did you keep records of your evaluations and treatment?
**A. Yes, I did.**
Q. Are those records made in the normal course of your profession?
**A. Yes.**
Q. And are those records made at or near the time of each consultation or evaluation?
**A. Yes.**
Q. Do you have those today --
**A. Yes, I do.**
Q. -- in front of you? Have you reviewed them in preparation for your deposition?
**A. Yes, I have.**
Q. All right. Doctor, if it's okay with you, I'd like to just mark that -- your file as Exhibit 1.
**A. Sure.**
Q. Okay. We'll just put that up at the top right here. Thank you very much.
**A. Sure.**

- - - -

(Thereupon, Plaintiff's Exhibit 1 was marked for purposes of identification.)

- - - -

Q. Are you prepared to talk about your treatment and



findings concerning Herbert Ross?
**A. Yes, I am.**
Q. Before we do that, could you tell us about your education and training as a clinical psychologist?
**A. Sure. I graduated from the University of Washington, in Seattle, Washington, with a Doctorate in Clinical Psychology focusing on the adult population. And that was in 1994. I was licensed to practice psychology in the State of Ohio in December 1995.**
**I completed a one-year American Psychological Association approved clinical internship and have been practicing in my current location since July of 1995.**
Q. So you have been in private practice for 19 years, going on 20 years?
**A. Yes.**
Q. For what type of things do you see patients?
**A. Primarily, I have focused on civil forensic cases involving various issues of psychological disability, assessing impairment and disability for state and agencies, such as workers' compensation, Industrial Commission, and for plaintiff as well as defense.**



**I provide treatment for psychological conditions, secondary to an injury. I do various evaluations for Fitness for Duty Return to Work, Adjustment to Disability, and a few reports for OPERS, and state agencies retirement systems, police and fire.**
Q. I forgot to ask you this: Prior to obtaining your Ph.D., your Doctorate in Clinical Psychology, where did you attend school?
**A. I did my undergraduate bachelor's at Case Western Reserve University, and majoring in psychology, as well as English. And I also got a Master's Degree in Psychology at the University of Washington prior to getting the doctorate.**

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(Thereupon, Plaintiff's Exhibit 2 was marked for purposes of identification.)

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Q. All right. Doctor, I want to hand you what has been marked Plaintiff's Exhibit 2. Can you identify that document for us?
**A. That is my res -- my curriculum vitae.**
Q. Or your resume?
**A. Resume.**
Q. And is that current and up-to-date?



**A. Yep. Yes, it is.**
Q. All right. Doctor, I notice on there that you see injured workers at the request of the Ohio Bureau of Workers' Compensation?
**A. Yes.**
Q. And do you perform disability evaluations at the request of the Ohio Bureau of Workers' Compensation?
**A. I have this year. Currently, I'm seeing -- I'm doing evaluations for the Industrial Commission of Ohio and not Ohio Bureau of Workers' Compensation.**
Q. All right. These disability evaluations, they involve psychological and mental health injuries?
**A. Yeah.**
Q. Would we call them independent medical examinations?
**A. Yes.**
Q. Do you provide the same disability evaluations for your own patients in Workers' compensation matters?
**A. Yes, I do virtually the same evaluation regardless of whom it's for; whether it's the defense, the plaintiff, or for Industrial Commission, Bureau of Workers' Compensation.**

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Q. Okay. Do you write written reports as part of your evaluations?
A. **Yes.**
Q. And did you write reports in Herbert Ross' case?
A. **Yes, I did.**
Q. Are those contained in your notes today?
A. **Yes, I have the report.**
Q. Have you offered professional opinions as a clinical psychologist in legal proceedings before today?
A. **Yes, I have.**
Q. Okay. Tell us, when did you first see Herbert Ross as a patient?
A. **I saw Herbert Ross on April 13, 2011.**
Q. And have you seen him since that date?
A. **Yes, I have.**
Q. Can you tell us approximately how many times you've seen him as a patient, and with what frequency?
A. **I -- I have seen him, my initial treatment session with him was on April 6 -- or September 6, 2011. And my most recent treatment session with him was on September 23, 2014. I have seen him approximately twice a month on average.**
Q. For about the last three years or so?

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A. **Yes.**
Q. Okay. So you've been actively participating in his professional care as a clinical psychologist during that time?
A. **Yes, I have.**
Q. When you first met with Herbert, did he give you a history as to why he was there, why he was seeing you?
A. **Yes, he -- he did.**
Q. Can you tell us briefly about that?
A. **Herbert told me that since he -- he had been -- well, actually he was originally injured; injured his back on June 29, 2009.**

**He was able to get some treatment, so that he was able to continue working, and attempted to do so until, I believe it was February 17, 2011, or thereabouts when he aggravated his back injury.**

**And he has not been able to work since then. So for him, he had been injured a number of times in the past, was always able to bounce back.**

**After the back injury, however, he found himself work -- able to work only while taking narcotic medication. And as a vice squad -- is that what they call it, a vice detective or -- he found that, you know, very difficult as he has,**

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**this is the type of person that he said he would go afterwards, someone who was taking narcotics.**

**So for him to have to take narcotics just to be able to manage his job, it was the source of great distress, shame, and eventually depression. He felt that he couldn't get through the day, he said, without taking Vicodin to function. That made him upset.**

**And after the aggravation of the back, his doctor of record, I believe that was Dr. Patel, at the time said, you know, this is not good. You have to be able to take down a large person in your job, to restrain suspects and run after them, and it would be risky for you to do that --**

Q. Because of the physical --
A. **-- given your back injury. And I believe, I saw him a couple months after that. And by that time, he -- he had not been able to return to his job. He was in a great deal of pain, not able to keep up with house chores that he normally would do.**

**And for him, his whole sense of self-worth was wrapped up in being a police officer and being the -- the man of the house, the provider. And when he wasn't able to do that, he became**

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**depressed.**

**He said he had been texting his wife, and he said something about -- he mentioned to her about not wanting to be around, or something that would have been suggestive of suicidal thoughts.**

**And his brother called him up a few minutes later. I guess his wife had told his brother, and the family got involved. And his wife wanted him to see a psychologist. So that's how he ended up coming to see me.**

Q. All right. And he related all this to you in the course of your evaluation with him?
A. **Yes, he did.**
Q. All right. Can you take us through the evaluation that you performed and then your course of treatment that you entered into with him?
A. **Sure. In all of these diagnostic evaluations, I do, what we call a clinical interview. And clinical interview forms the basis of a psychological evaluation.**

**Clinical interview includes clinical observations, meaning, through the eyes of a trained psychologist, what kind of, you know, behaviors, both verbal/nonverbal are you seeing?**

What kind of presentation is the person making? What is their stream of speech like? What is their eye contact like? What is their body posture like? What is their affect? And affect is just their outward expression.

We talk about having a restricted affect, meaning, that there is very little outward expression, all the way to, you know, a very full, very expressive affect. So that can vary.

And then the underlying mood, which can be determined through -- by observation and listening to the content of their speech and their -- observing their behavior, we could determine what type of mood the person is -- is having.

So there is the outward expressions, which is the affect, the internal or more stable mood, which is predominant. And those two aspects are very important to zero in on when you're a -- when you're a psychologist making a diagnosis.

So there is a description of the individual. Then I ask him what is his physical -- what is the reason for coming. What kind of physical problems is he having.

He described the four most problems as



numbness in the outside of the right thigh, with difficulty driving, because it's his driving leg. Pain and numbness, cramping, difficulty sleeping due to pain and racing thoughts.

And then I asked him to tell me what kinds of emotional distress he's noticing. And for him, his big thing was that he is a southern man. And that he grew up in a way where the man was the head of the household. And it was his first and foremost responsibility to provide for the family.

And for him, the kind of person he is, four years in the army, followed by six years in the coast guard, and then immediately after that, becoming a police officer, he has always been in a very physical -- I guess, what do you call it? The common denominator would be some sort of a defense or protective kind of law enforcement type of capacity of work.

And to find himself physically unable to -- to do that, to meet the expectations of his job, and to bring in the income that he promised his family he would provide for them, that that was -- gave him a sense of worthlessness, uselessness. And he felt -- he felt utterly, I



guess alienated from the person that he used to be, in other words, his identify.

So then I asked for the history of his injury. And he gave me the history of his injury. As I said, he did have some treatment after the 2009 injury. He was able to get some physical therapy, some -- some blocks, and some medication that allowed him to function.

For him, you know, to have to take Oxycodone as a vice detective, you know he's constantly worried he was going to get hooked, and it was very hard for him, especially because of the kind of work he did.

Q. Can I interrupt you?

A. Yes.

Q. Did he discuss with you how he felt about being a police officer?

A. Yes. He took great pride in being a police officer. He was -- it sort of suited his personality really well, because he's very physical, works out. He likes being in a position where you have to act fast. And this became a tremendous problem for him, and adjusting to the injury, because he never had to think before he acts, he always acts.



And when you have a back injury, you can't just act, you have to think before you could act and -- and that was hard for him to adjust to.

So he -- he loved his job. He had never been reprimanded. He was honorably discharged from the army, and then, you know -- so this is something, stable -- stable career for him, and something he enjoyed a great deal.

Q. Did he express to you about how he felt about not being able to return as a police officer?

A. Many times. And something that he couldn't believe was real. He was struggling, because many times he wanted to go back, even though it was not recommended by -- really I don't think that any of the examining physicians thought that it was a good idea for him to return to full-duty.

And he wanted to take the risk. And then -- then he was thinking, well, you know, what could happen if he -- if he couldn't meet the challenges. So, you know, he was struggling with that, and ultimately he gave in and said, you know, I can't -- I can't meet the full requirements of the job.

Q. The physical requirement?
A. **The physical requirements. So as he had never -- talking about somebody in the army, coast guard, police.**
Q. Right.
A. **So it's very much one type of functioning that he's done professionally. And he's never -- he knew nothing about anything else, so other alternative types of ways to make a living.**
Q. During the course of your treatment with him over the last three years, did he ever express a desire to try to return to work?
A. **Many times. He -- he would hope that, you know -- he -- he wanted to. His family, particularly his wife, was worried about, you know, what could happen if he would be reinjured, because his back was vulnerable, and he would have problems with his, you know, radiating pain into the leg and difficulty with just prolonged sitting or walking. And so it was something he struggled with a lot, and --**
Q. Let me go back in time to your initial --
A. **Sure.**
Q. --- the initial evaluation in April. How long of a meeting did you have with him? How long did



that initial evaluation take?
A. **I -- I met with him twice. I do evaluations like this slowly. And it's not unusual for me to meet twice with a person. My initial meeting is an hour-and-a-half, so my second meeting must have been an hour. So I did the evaluation, and I asked him about prior psychological history.**

**He said that while he was exposed to a lot of trauma, and that he -- you know, in his work in the coast guard, dead bodies and things like that, he didn't experience any post-traumatic stress type of symptoms.**

**He did say that something, that after the back injury, he managed to cope emotionally until he started having to take Vicodin to function at work. And he, you know, said he knew he was screwed when he had to start taking Vicodin to go to work.**

**So the depression had -- sort of had its origins there. I mean, he -- he's a -- as I said, he had been injured in the past, he has been exposed to dead bodies and stuff, and he hadn't had any major problems.**

**But having to be a vice detective and take Vicodin to function bothered him a lot. And --**



Q. Doctor, was there any evidence of any prior psychological injuries or treatment?
A. **I believe he saw a psychologist. Let's see, there was no -- I don't believe there was any treatment. If there was --**
Q. Did he see a psychologist, because a friend had been killed on-duty?
A. **That's what I recall him saying that he had a couple visits with someone, a colleague that had been killed and --**
Q. Any record of any prior psychological diagnosis or injuries or workers' compensation?
A. **Not that I'm aware. And not that he's -- no.**
Q. Okay. All right. Doctor, based upon a reasonable degree of psychological probability, did you reach a working diagnosis after that -- the two April 2011 evaluations?
A. **I did.**
Q. What was your diagnosis?
A. **Well, you know, as part of my evaluation, I also gave some tests. I gave a MMPI, and I also gave a Beck Depression Inventory. I --**

**You know, on the Beck Depression Inventory, he did report a severe level of depression. Although, on the Beck Depression Inventory,**



**scores can be inflated due to the presence of physical things, like pain. In other words, not being able to sleep could be due to depressive thoughts, or could be due to his pains keeping him up.**

**So scores -- I mean, that measure doesn't distinguish what's the cause of the symptoms. It could be high due to physical symptoms, as opposed to psychological.**

**But his MMPI was typical of most police officers, in that he presented a favorable self-image. And this is something you see in, you know, with police officers or candidates for -- you know, police candidates, that certainly are more guarded, more defensive, projecting a positive attitude.**

**And really he was -- it's -- I felt that although the profile was valid, that given that it shows that's he's presenting a favorable self-image, that probably he wasn't admitting to the -- that he was not admitting to the full extent of his depressive symptoms.**

Q. Okay.
A. **So -- and then I asked him about his symptoms, and found that he met criteria for major**

**depressive disorder.**

**Major depressive disorder is a psychological diagnosis. It is a mood disorder. It is characterized by depressed mood most of the day, nearly every day. It is -- one needs to have five of eight possible symptoms.**

Q. And he met that?

**A. And at the time, yes, I -- I felt he met that.**

**He was sort of on the border. I mean, he met five. He met the minimum number. But I did find him to meet criteria for a major depression.**

**So he had the depressed mood most of the time, markedly diminished interest and pressure in all or almost all activities nearly every day. He had lost interest in things that would be normally enjoyable for him.**

**And he indicated that, you know, he no longer cares to play video games, spend time with his daughter, socializing with his friends. He also had experienced a weight loss due to poor appetite. That's another symptom that you see in major depression. And he experienced insomnia, which was due to a combination of pain and depressive thoughts.**

**I saw some agitation, but not enough, in my**



**opinion, to qualify for, as that, meeting that symptom. He had a great deal of fatigue and loss of energy, so that was another symptom of major depression.**

**Feelings of worthlessness were very obvious. And so he did have that symptom. So -- and actually, there were -- there are nine. There's -- there's diminished ability to concentrate and thoughts of death or suicide.**

**I didn't at the time see as much evidence of those two, so -- but I did feel that he met criteria for major depression.**

Q. All right. Doctor, that would have been as a result -- let me back up. In these two evaluations in April of 2011, you did a clinical interview, correct?

**A. Yes.**

Q. You noted his affect or mood?

**A. Yes.**

Q. You would have performed a mental status evaluation?

**A. Yes.**

Q. And you would have given him some written tests?

**A. Yes. And in the mental status evaluation, we take a look at concentration, short-term memory,**



**long-term memory functions, suicidal ideation, the presence or absence of, and things like judgment, reasoning. I administered the Beck Depression Inventory, as well.**

Q. These tests that you administered, as a clinical psychologist, do you rely solely on the results of those tests to reach your diagnosis?

**A. No. Ethically, I cannot, as a psychologist, make a diagnosis on the basis of a test alone. That would be considered unethical. I can make a diagnosis on the basis of a thorough clinical interview, however, without giving any tests.**

Q. But in your case -- in this case with Herbert, initially, you did both?

**A. I did both.**

Q. All right. And as a result, you reached a diagnosis that you've told us about. And then did you enter into a course of treatment after that visit with him?

**A. Yes, I began treatment a few months later.**

Q. Okay. I know you testified that you saw him several times a year. I think you said twice a month at times for the last three years or thereabouts?

**A. Yes.**



Q. I don't want to go through every single one of those visits.

**A. Don't worry. Yeah.**

Q. I would like to know, though, if you could just summarize what the treatment was and what affect, if any, it's had on Herbert?

**A. Yes. Herbert being -- never -- not what I would consider a psychologically minded individual, more of a traditional kind of man who had never -- had very little experience with the psychological world. You know, he -- it took some time to get comfortable with the idea of seeing a psychologist.**

**And so we -- but he seemed very motivated. He seemed very aware that, you know, that he -- he was not himself.**

**And he has a wife who expressed her observations and concerns about his -- his irritability, agitation, short temper, withdrawal, kind of pulling away from people. And he reported difficulty concentrating. I remember he told me he ran a stoplight once, you know, preoccupation --**

Q. Right.

**A. -- thoughts of worrying about the future, worried**

about how he will provide for his family.
Q. Have you had occasion to treat other police officers?
A. Yes.
Q. Have you observed common traits or common culture among these police officers?
A. Yes. I think of all the groups that I have treated in 19 years of doing this, police officers fall the far -- fall the hardest when it comes to not being able to continue doing their job for physical reasons.

I like to tell them that they're the most psychologically fragile of all the different groups that I've -- the professional groups that I've worked with.

So there's a lot of -- they are very uncomfortable about expressing their emotions, expressing feelings of -- of fear and sadness. And it's more comfortable for them to express it as anger.
Q. And to be tough?
A. And to be tough. They are also the most non-adaptive types that I have ever come across.
Q. What does that mean?
A. In other words, their ego and their self-image is



so invested, entirely invested in being a wearer of the badge, that really anything else is unsatisfactory, it doesn't measure up. It's less.
Q. Did Herbert tell you about socializing with other police officers when he was injured, and whether he was able to do that or not?
A. He had times where he did, but he felt kind alienated. He --there was a lot of shame. He had, as I said, been injured in the past, and it didn't take him out. So -- and he -- it's a very high risk job, people get hurt. So he, you know, he felt -- I mean, it was embarrassing for him.
Q. Doctor, your treatment over the past three years, did that consist of -- of therapy sessions, or what happens when he sees you, I guess is my question?
A. He's always early to his appointments. And that is interesting, because that doesn't usually happen. But he's always early to his appointments.

There are a few times where he had to cancel or miss, but he was -- you know, he very -- I got the feeling that he really desperately wanted to improve, so he would be easier to live with.



He was afraid of losing his family. He knew he was irritable. He had episodes of road rage, which frightened his family. And his wife had come in with him a few times to express her concern about his anger, his road rage, or his just withdrawal. So he felt he had a -- they had a very good marriage, and he withdrew. He kept -- he withdrew from them.

So, you know, we would focus on interpersonal skills. We would focus on finding a purpose. Because he had this very much black and white thinking that either you're, you know, doing your job as police officer, or you're doing -- or you're doing your job as, you know, doing chores, taking care of your property, or you are really not doing anything.

And for him, he felt like he was useless, doing nothing. And it was hard for him to get a sense of accomplishment of any kind when he wasn't working.
Q. Since your treatment with him, have you noticed an improvement?
A. I have. I've noticed -- as I said, adjustment for police officers to not being able to do their job, is very, very difficult. They have a bias



against, you know, that there really isn't anything else that measures up to being a cop. And it is a little bit of an ego thing, that you could never possibly, you know, be as grand as being as police officer.

So he -- that anyone that gets hurt and can't work could possibly be a wimp, a chance of that, and no one wants that.

So, you know, he -- he has -- he has sort of been kind of up and down. And a lot of it depends on exacerbation of physical symptoms, because, you know, his -- his injury was pretty significant, and he had tried radio frequency ablation, he tried a number of different things without really getting enough relief.

Now the -- we -- he did begin to accept the idea of doing something different, possibly, you know, something that would involve helping people. But still there were a lot of uncertainties. He thought, oh, gosh, you know, I'm 51 years old, and I've got this physical -- some limitations. And so he's very anxious about the future.

And -- but the thing that made all the difference was in May he had a fusion, and --

Q. What is a fusion?
**A. Well, he had a lumbar fusion. He had two herniated disks in the back. And one day, he had an episode of incontinence, he wet himself. And his surgeon, you know, started talking about fusions after that. He was, you know, very, very anxious, but he had that, and he's pain-free. He's com -- I mean, I'll find the note.**
Q. Up to this point of September 2014 --
**A. Yeah.**
Q. -- his pain symptoms have greatly improved, because of that lumbar fusion?
**A. Yes. I mean, it's -- it's been tremendously successful. And one thing that he -- he has not had and, you know, he believes -- being a cop, patience is not something that is really important.**
Q. Patience?
**A. Patience.**
Q. P-a-t-i-e-n-c-e?
**A. Yes. Being able to think first, to not -- not impulsively act. And for this to be successful, he knows he has to follow his surgeon's instructions to a T --**
Q. All right.



**A. -- and that is not easy for him. So it is important for him to do that. He has committed to following her recommendations to a T. And he is. And --**
Q. Based on what you have described, would it be fair to call Herbert before this accident a man of action?
**A. Exactly.**
Q. And after this physical injury to his back he was not able to be a man of action?
**A. Not at all. And never -- never been in that position. More than anything he wants to -- his ideal is being a police officer. The thing that was in between him and being a police officer was his back.**
Q. Right.
**A. His back is not causing pain anymore. He doesn't have radicular symptoms. He could walk without difficulty or numbness. And he wants to return to his job.**
Q. All right. He told you that he had sustained this back injury as a result of a car accident in June of 2009?
**A. Yes.**
Q. And he told you that that car accident occurred



as a result of -- while he was working as a police officer for the City of Cleveland?
**A. Yes.**
Q. Okay. Doctor, let me ask you, do you have a professional opinion, based upon a reasonable degree of psychological certainly, whether Herbert Ross sustained a psychological or mental health injury as a result of that workplace auto accident of June 26, 2009?
**A. Yes.**
Q. What is your opinion?
**A. My opinion is that Herb developed depression as a direct result as of the injuries he suffered on June 26, 2009.**
Q. Would that specifically be depressive disorder, not otherwise specified in your clinical psychologist lingo?
**A. Yes.**
Q. Okay. Thank you, Doctor. I would like for you to -- I would like to ask you a couple other questions, and I'm almost done. The defendants had Herbert examined by Dr. George Serna. You are aware of that?
**A. Yes.**
Q. Have you been provided with a copy of Dr. Serna's



report?
**A. Yes, I have.**
Q. I would like for you to assume that Dr. Serna will testify in the trial of this matter. And that he will try -- he will testify consistent with that report that you have been provided, and that he will offer his professional opinion that Herbert Ross is a malingerer or, in essence, he's faking this psychological injury.
Assuming those facts to be true, as Dr. Serna will give that testimony, do you have a professional opinion, based upon a reasonable degree of psychological probability, as to whether or not Herbert is a malingerer or is faking this psychological or mental health injury?
**A. It is my professional opinion that Mr. Ross is not a malingerer. I am a seasoned psychologist and may not be the smartest in the world, but I've never had anybody trick me for three-and-a-half years into treating them for a condition that wasn't there.**
MR. BARBOUR: All right. Doctor, I don't have any other questions for you. Thank you very much.

THE WITNESS: Thank you.

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EXAMINATION OF MARIAN M. CHATTERJEE, PH.D.

BY MR. SCOTT:

**Q.** Dr. Chatterjee, my name is Joseph Scott. And I, together with Attorney Lisa Mack, seated here next to me, have the privilege of representing the City of Cleveland in this proceeding. And I thank you for giving us the opportunity to speak with you this afternoon?

Doctor, you testified that part of your initial evaluation of Mr. Ross involved the test, the MMPI-2 and the Beck --

**A. Yes.**

**Q.** -- Test that you administered, correct?

**A. Yes.**

**Q.** And those are really two different kinds of tests that a psychologist might use to assist in making a diagnosis; is that fair?

**A. Yes, that's part of it.**

**Q.** Okay. And they're tools, right?

**A. They are tools.**

**Q.** So, in this case, the MMPI-2, am I correct that that test differs from the Beck test, one of the way that it differs, is that it has sort of a



built-in test for reliability?

**A. It has various sub-scales for validity and reliability.**

**Q.** Okay. And those sub-scales for validity and reliability are a way of gauging whether or not a particular patient is answering the questions accurately and truthfully; would that be fair?

**A. Well, it is kind of hard to say that. But what it is, does is, there's -- they have ways to check for whether someone is likely to have been responding randomly or to have a response by us.**

**In other words, they are answering all the questions true or all the questions false, whether they are reporting symptoms that have a low frequency of being reported.**

**Q.** Okay. And in this case, and I think you described this particular test that Mr. Ross took, the MMP1-2 as a valid profile?

**A. Yes.**

**Q.** Okay. So you felt that this was a valid test that Mr. Ross took in April of 2011, correct?

**A. Well, yes, in fact, it was valid.**

**Q.** And, by the way, your understanding from the history that Mr. Ross gave you was that he had the initial injury as a result of the motor



vehicle accident in 2009, correct?

**A. That the physical injuries came from that, yeah.**

**Q.** And then there was a period of time when he was trying to work?

**A. Yes.**

**Q.** And then finally in February of 2011, he was not able to return to work thereafter; is that your understanding?

**A. Right.**

**Q.** So this MMPI-2 Test and the Beck Test you gave were a couple months after Mr. Ross was not able to return to work; is that your understanding?

**A. Right. And, of course, he, not knowing whether he was would go back to work, yeah.**

**Q.** So -- by the way, now the MMPI-2 Test results, is that part of your file?

**A. The actual -- I believe -- I mean, I don't have it here, but the Ross scores, you are talking about, or --**

**Q.** No, I just wonder if it's in your file, and if not, I could hand you a copy and we could mark it, just to make sure we have it in front of us.

**A. Uh-huh.**

MR. SCOTT: Let me mark this as A.

- - - -



(Thereupon, Defendants' Exhibit A was marked for purposes of identification.)

- - - -

**Q.** And, Dr. Chatterjee, handing you what has been marked as Defendants' Exhibit A. Could you, please, tell us if that is the MMI -- MMPI-2 Test that you gave Mr. Ross in April of 2011?

**A. Yes, that is.**

**Q.** Okay. Now part of that packet that I just handed you, Defendants' Exhibit A, includes an interpretive report; is that correct?

**A. Yes.**

**Q.** Okay. And as you indicated this was a -- a valid test, correct?

**A. Yes.**

**Q.** And part of the interpretive report beginning on -- mine is just slightly out of order. If I could have just a second here.

Turn to page five of the interpretive report, under symptomatic patterns.

**A. Okay.**

**Q.** The interpretive report from Mr. Ross indicates that the client's profile is within the normal range; is that correct?

**A. Yes.**

Q. Okay. This particular test result did not suggest that Mr. Ross had any psychological or mental condition at all, did it?
**A. Yes. Yes. No, it did not suggest -- the MMPI was within the normal range.**
Q. Okay.
**A. But it's important to notice that it said that he attempted to present somewhat favorable self-image, so it would be taken with a little bit of a grain of salt.**
Q. All right. Further down on that page under interpersonal relations, it describes -- the report describes Mr. Ross as quite outgoing and sociable. He has strong need to be around others. He is gregarious and enjoys attention.

Personality characteristics related to social introversion/extraversion tend to be stable over time. This client is typically outgoing and his sociable behavior is not likely to change if he is retested at a later time, correct?
**A. Um-hmm.**
Q. Yes?
**A. Yes.**
Q. Thank you. Okay. If we turn to page 6 of that report, under diagnostic conditions, again, the



report indicates his clinical profile is within normal limits, no diagnostic considerations are provided for individuals in this elevation range, correct?
**A. Yes.**
Q. Thank you. And I believe towards the end of that interpretive report -- well, I guess that was the passage, his condition was not anticipated to change if retested at a later time.

Now, Doctor, the Beck Test that you gave -- we'll strike that -- part of the evaluation of the MMPI-2 Test is that -- my understanding is it's given to individuals with known conditions; is that correct?
**A. That the MMPI is given to individuals with known conditions?**
Q. Correct.
**A. It could be given to anyone.**
Q. Okay. Well, as part of the value of the test, part of the way it's used, that if a patient answers similar to somebody with a known condition, it's more likely that they also have that condition; is that how that works?
**A. No. It's -- I mean, it can be used for -- for diagnostic purposes. It can be -- I'm not quite**



**sure I understand what you mean.**
Q. Well, let me ask it this way: Certainly the MMPI-2 is designed to test for any number of -- of mental condition; is that fair?
**A. It provides a profile of somebody's personality functioning.**
Q. Okay. And it could detect -- the MMPI could be used to detect any number of conditions, such as anxiety or depression or other disorders, correct?
**A. Yeah, it can be -- it's used to assist making a diagnosis in conjunction with a number of other things, other tests, clinical interview.**
Q. And's certainly capable -- if -- if an individual had answered the test in such a way, as to suggest that they suffered say from depression or anxiety, that would be reflected in the interpretive report, correct?
**A. It's possible.**
Q. Okay. Well, is that what you would typically expect?
**A. If a person was suffering from depression, as I said, it is possible.**
Q. Okay. Now the -- the Beck Test that you administered --



**A. Yes.**
Q. -- does not have the same built-in scales for testing reliability --
**A. No.**
Q. -- is that correct?
**A. No. It's much shorter. Very, very widely used and accepted depression inventory.**
Q. Okay. And the -- the test that you actually gave Mr. Ross, the one test is actually called Beck Depression Inventory, correct?
**A. Yeah, Beck Depression Inventory 2.**
Q. Beck Depression Inventory 2, that's actually in the title of the test?
**A. Yes.**
Q. And I've seen the test results for the tests that Mr. Ross were given, and it appears that the entirety of the test is composed of about 21 questions --
**A. Yes.**
Q. Is that correct? The -- do you know how many questions are in the MMPI-2 Test?
**A. 500 and -- oh, gosh. I'll tell you, 567.**
Q. All right. 567 questions with the MMPI-2.

All right. And you also indicated that the -- the Beck Inventory is subject to possibly -- I

don't want to misuse your term, but may be affected by pain condition?

**A. Yes.**

Q. Something to that effect?

**A. The scores can be elevated due to various physical conditions.**

Q. Okay. Now, the Beck Tests that you gave, were indicative of severe depression; is that fair?

**A. The score was in the severely depressed category.**

Q. Okay. And you gave this Beck Test, the first one I have is April 13 of 2011. Was that the same day that Mr. Ross took the MMPI-2?

**A. Oh, he would have taken that, date assessed, 5/9. Well, I don't know if that's -- they were within a month of each other. This MMPI-2 has date assessed 5/9.**

Q. Okay. You think that is the same day that he took the test?

**A. You know, it -- it's a very long test, and people with pain don't sit real well and focus for that long. So it could have been on a different day that he took that.**

Q. All right. So these are two very different test results that we have. I mean, one indicating severe depression, and the other indicating test



results that are within normal limits; is that fair?

**A. They are two very different tests by nature. That -- that's the strength of the report, you give a number of different tests combined with a clinical interview, and no one piece of data determines it. The clinical interview is the -- the key part of the evaluation.**

Q. You indicated that your understanding today is that Mr. Ross is pain-free?

**A. His words, I could tell you his words were -- I mean, he would have post-surgical pain. So, I mean, for him the -- the fusion was -- exceeded his exceptions, and -- okay. What he said was on August 4, that immediate relief on all aspects. So that was his -- his experience after the fusion, was that he had immediate relief, so --**

Q. And that fusion was --

**A. I put in the words pain-free. He may not be pain-free, but he had immediate relief on all aspects.**

Q. And he had the surgery when?

**A. On May 7.**

Q. So approximately four --

**A. Three months --**



Q. Three months?

**A. -- was my first visit with him.**

Q. Oh, you mean three months after the surgery?

**A. Yeah.**

Q. All right. And did he then relate any change in his daily activities as a result of the surgery that he had had?

**A. Well, he was recovering. And he has to wear a bone stimulator for a year. However, he is in less pain.**

Q. Did you feel that his symptoms of depression had improved?

**A. Yes. On August 4, I administered the Beck Depression Inventory, again. And it was in the moderate range, which indicates significant psychological improvement from his scoring the severe -- the severe range.**

**So, at least, just in looking at the Beck Depression Inventory, there had been improvement in the score. And, as noted, that Beck needs to be taken with a grain of salt, because discomfort, which would be natural post-surgically, could be accounting for some symptoms of, you know, difficulty sleeping or fatigue.**



Q. Were you given Dr. Serna's test results?

**A. No, I -- he -- just -- just his report.**

Q. Okay. You -- when we were discussing the reliability scales that are built into the MMPI, if those scales suggest that a patient is not accurately answering; answering all questions true, answering all questions false, whatever, that obviously you would make the test results invalid, correct?

**A. You know, there is a number of different validity indicators and reliability indicators. And the number of those grows by the year.**

**You know, so the validity indicators can tell you about the response style of the individual taking the test. And how they answered, if you compare the first part of it to the last part of it, and you -- if you look at the frequency of endorsed symptoms relative to various normative group.**

**If it is a low frequency endorsement. Or the -- yeah, there's one validity indicator that reports on the -- the frequency of low frequency endorsed items. So if you have a large number of low frequency endorsed items, then that scale would be elevated.**

Q. Well, let me ask you this: And, Doctor, certainly one of the things that you would be on the lookout for in evaluating a patient, would be exaggeration of symptoms, correct?
**A. Yes.**
Q. Okay. And is it possible to detect exaggeration of symptoms from test results of a test, such as the MMPI-2?
**A. Not alone.**
Q. Okay. But it may be indicative of exaggeration of symptoms?
**A. On that test, it -- it will tell you about the individual's performance on that test. But what -- this is why it's critical to have a number of other indices to rely on besides a single test.**
**So you compare their subjective report with your objective observations. So if this -- the test showed that the person is reporting all kinds of -- saying that, yes, I've had this, lists hearing voices and having, you know, thoughts of wanted to kill myself, I would expect them to be reporting something of that nature during the clinical interview.**
**So I would look to see whether the kinds of symptoms that they are endorsing on the MMPI are**



**similar at all to what they are telling me. And whether my clinical observation shows some kind of -- that the individual's behavior and presentation would be congruent with their reported symptoms.**
Q. In this case, you have not been provided with Dr. Serna's test results, correct?
MR. BARBOUR: Objection.
**A. No, just what he wrote in the report.**
Q. Okay. So you don't know if those test results were suggestive of exaggeration?
**A. Yes, I do, because he said that in the report.**
MR. SCOTT: Okay. Thank you, Doctor. That's all I have.
THE WITNESS: Okay.
- - - -
RE-EXAMINATION OF MARIAN M. CHATTERJEE, PH.D.
BY MR. BARBOUR:
Q. Doctor, a couple things. First of all, is there anything that counsel for the defendant brought up that causes you to change your opinion that you gave when I was asking you questions?
**A. No, it doesn't.**
Q. Doctor, as I understand it, you testified earlier that you would not rely or you cannot rely -- I



don't want to put words in your mouth -- solely on the results of a test to make a diagnosis in a clinical psychological setting?
**A. No. And clinical psychology, I can't ethically make a diagnosis on any individual as a result of my clinical interview alone. I cannot ethically make a diagnosis of an individual on the basis of a test alone.**
Q. And -- and is that pursuant to the American Psychological Association --
**A. Yes.**
Q. -- guidelines?
**A. Yes.**
Q. And that's your professional membership organization --
**A. Yes.**
Q. -- that sets rules that all of you try to live by in your profession?
**A. Yes, it is.**
Q. All right. Doctor, when I go see my internist, he could give me a blood test, and he could tell me that my cholesterol is too high.
These MMPIs and these Beck Diagnostics, they're not that kind of test, are they? They are not a definitive answer to your psychological



--
MR. SCOTT: Objection.
Q. -- condition, or are they?
**A. No, there is no -- psychological conditions are not quantifiable. They -- there is no dipstick to measure how much depression a person has.**
**And what is critical, I believe is to have a trained psychologist doing a very thorough clinical interview and mental status evaluation, as well as getting details on an individual's pre-incident functioning.**
**In Mr. Ross' case, his preinjury functioning and his postinjury function with respect to behavior and psychological functioning. And as much corroborative data, in other words, ideally family reports, people think he's acting different.**
**Is there any medical records from doctors showing that he is, in fact, experiencing a significant incident, physically, mentally. So, in other words, you for -- as a psychologist, there is no -- there is no way to quantify or to measure any psychological condition.**
**And the strength of a diagnosis rests on having a very thorough clinical interview with a**

**very thorough mental status evaluation, and as much in the way of history and corroborative information, corroborative data, family reports, doctors' reports, employers' reports as possible, and a number of psychological tests.**

Q. Doctor, you performed, I think you testified earlier about an hour-and-a-half of initial evaluation?

**A. Yes.**

Q. And then a few days later about an hour --

**A. Yes.**

Q. -- I think you testified?

**A. Yes.**

Q. And then you've testified that you've seen Herbert since September 2011 up into September of 2014?

**A. Yes.**

Q. Twice a month, on average?

**A. On average, yes.**

Q. So that would be certainly over 40 or 50 times?

**A. Yes.**

Q. And you used all of those observations in reaching your conclusions that you've voiced today?

**A. Yes, I have. I mean, I've had to give him --**



**I've had to give him my cellphone number, because I was as worried as I was about his suicidal potential.**

Q. After Herbert saw Dr. Serna at the City of Cleveland's request, did you have an opportunity to meet with him?

**A. Yes, I did.**

Q. I meant Herbert not Dr. Serna?

**A. Yes.**

Q. And what did Herbert tell you about that visit with Dr. Serna?

**A. Herb said he was in and out of there in less than 45 minutes. He was told that it would last between two to four hours. He had just been examined by another person a month before.**

**He had -- his daughter was in the band, and her school was having a football game, and he and his wife had to take her there, and they were going to go. He needed to finish this fast.**

**He said, Dr. Serna asked him demographic questions, where do you live, that sort of thing, then put him in front of a computer and did not give him any specific instructions. He answered -- he read the first few words of the thing and answered true or false as to whether that had**



**ever -- he ever felt that way.**

**Okay. Then he had a one-page paper and pencil test, which Dr. Serna never mentioned. Then he was asked by Dr. Serna -- then Dr. Serna talked to him for five to seven minutes total, asked him about my marriage, my accident. Have you ever thought of suicide?**

**And then the last question was, do you think all your depression would end if you got your job back? And he said, yes. And that was it. So I would not expect anyone, even a speed reader to be able to complete the MMPI, another paper and pencil test, and what I would consider an appropriate clinical interview.**

**There's no mental status evaluation on here. There is no mention of affect and mood. Just talks about, his speech was -- that his speech was direct and relevant to the topic, suggesting an absence of a thought disorder. There was no evidence of acute psychotic disturbance, and he reported of none in his life time.**

**Now, that's not a mental status evaluation. I don't see the clinical interview. I don't see what I would -- what I would do when I was making a psychological diagnosis.**



MR. BARBOUR: Okay. Thank you, Doctor.

MR. SCOTT: Nothing further.

THE VIDEOGRAPHER: You have the right to review this videotape in its entirety, or you may waive that right.

THE WITNESS: I'll waive it.

THE VIDEOGRAPHER: Thank you. Will counsel for each party waive the filing of the video.

MR. BARBOUR: Yes.

MR. SCOTT: Yes.

THE VIDEOGRAPHER: Thank you. We are off the record.

# CERTIFICATE

The State of Ohio, ) SS:
County of Cuyahoga.)

I, Chana Margareten, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed by computer-aided technology under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 20 ____.

_____

Chana Margareten, Notary Public, State of Ohio
55 Public Square, Suite 1332
Cleveland, Ohio 44113
My commission expires March 10, 2016

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