

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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3

I N D E X

EXAMINATION	
MARIAN M. CHATTERJEE, PH.D.	
BY MR. BARBOUR	4
EXAMINATION	
MARIAN M. CHATTERJEE, PH.D.	
BY MR. SCOTT	33
RE-EXAMINATION	
MARIAN M. CHATTERJEE, PH.D.	
BY MR. BARBOUR	46
Plaintiff's Exhibit 1	5
Plaintiff's Exhibit 2	7
Defendants' Exhibit A	36

OBJECTION INDEX

MR. BARBOUR	46
MR. SCOTT	48

2

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(216) 664-2894

On behalf of the Defendants.

4

- 1 THE VIDEOGRAPHER: We are on the
- 2 record.
- 3 MARIAN M. CHATTERJEE, PH.D., of lawful age,
- 4 called by the Plaintiff for the purpose of
- 5 examination, as provided by the Rules of Civil
- 6 Procedure, being by me first duly sworn, as
- 7 hereinafter certified, deposed and said as
- 8 follows:
- 9 EXAMINATION OF MARIAN M. CHATTERJEE, PH.D.
- 10 BY MR. BARBOUR:
- 11 Q. Could you tell us your name, please?
- 12 A. **Marian Chatterjee.**
- 13 Q. And what is your profession?
- 14 A. **I'm a clinical psychologist.**
- 15 Q. Are you licensed by the State of Ohio as a
- 16 psychologist?
- 17 A. **Yes.**
- 18 Q. Did you see Herbert Ross as a patient?
- 19 A. **Yes.**
- 20 Q. Have you seen him multiple times as a patient?
- 21 A. **Yes, I have.**
- 22 Q. Have you evaluated him?
- 23 A. **Yes.**
- 24 Q. Have you provided psychological treatment to him?
- 25 A. **Yes.**

1 Q. And did you keep records of your evaluations and
2 treatment?

3 A. Yes, I did.

4 Q. Are those records made in the normal course of
5 your profession?

6 A. Yes.

7 Q. And are those records made at or near the time of
8 each consultation or evaluation?

9 A. Yes.

10 Q. Do you have those today --

11 A. Yes, I do.

12 Q. -- in front of you? Have you reviewed them in
13 preparation for your deposition?

14 A. Yes, I have.

15 Q. All right. Doctor, if it's okay with you, I'd
16 like to just mark that -- your file as Exhibit 1.

17 A. Sure.

18 Q. Okay. We'll just put that up at the top right
19 here. Thank you very much.

20 A. Sure.

21 - - - -

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

24 - - - -

25 Q. Are you prepared to talk about your treatment and

1 findings concerning Herbert Ross?

2 A. Yes, I am.

3 Q. Before we do that, could you tell us about your
4 education and training as a clinical
5 psychologist?

6 A. Sure. I graduated from the University of
7 Washington, in Seattle, Washington, with a
8 Doctorate in Clinical Psychology focusing on the
9 adult population. And that was in 1994. I was
10 licensed to practice psychology in the State of
11 Ohio in December 1995.

12 I completed a one-year American Psychological
13 Association approved clinical internship and have
14 been practicing in my current location since July
15 of 1995.

16 Q. So you have been in private practice for 19
17 years, going on 20 years?

18 A. Yes.

19 Q. For what type of things do you see patients?

20 A. Primarily, I have focused on civil forensic cases
21 involving various issues of psychological
22 disability, assessing impairment and disability
23 for state and agencies, such as workers'
24 compensation, Industrial Commission, and for
25 plaintiff as well as defense.

1 I provide treatment for psychological
2 conditions, secondary to an injury. I do various
3 evaluations for Fitness for Duty Return to Work,
4 Adjustment to Disability, and a few reports for
5 OPERS, and state agencies retirement systems,
6 police and fire.

7 Q. I forgot to ask you this: Prior to obtaining
8 your Ph.D., your Doctorate in Clinical
9 Psychology, where did you attend school?

10 A. I did my undergraduate bachelor's at Case Western
11 Reserve University, and majoring in psychology,
12 as well as English. And I also got a Master's
13 Degree in Psychology at the University of
14 Washington prior to getting the doctorate.

15 - - - -

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

18 - - - -

19 Q. All right. Doctor, I want to hand you what has
20 been marked Plaintiff's Exhibit 2. Can you
21 identify that document for us?

22 A. That is my res -- my curriculum vitae.

23 Q. Or your resume?

24 A. Resume.

25 Q. And is that current and up-to-date?

1 A. Yep. Yes, it is.

2 Q. All right. Doctor, I notice on there that you
3 see injured workers at the request of the Ohio
4 Bureau of Workers' Compensation?

5 A. Yes.

6 Q. And do you perform disability evaluations at the
7 request of the Ohio Bureau of Workers'
8 Compensation?

9 A. I have this year. Currently, I'm seeing -- I'm
10 doing evaluations for the Industrial Commission
11 of Ohio and not Ohio Bureau of Workers'
12 Compensation.

13 Q. All right. These disability evaluations, they
14 involve psychological and mental health injuries?

15 A. Yeah.

16 Q. Would we call them independent medical
17 examinations?

18 A. Yes.

19 Q. Do you provide the same disability evaluations
20 for your own patients in Workers' compensation
21 matters?

22 A. Yes, I do virtually the same evaluation
23 regardless of whom it's for; whether it's the
24 defense, the plaintiff, or for Industrial
25 Commission, Bureau of Workers' Compensation.

1 Q. Okay. Do you write written reports as part of
2 your evaluations?

3 A. Yes.

4 Q. And did you write reports in Herbert Ross' case?

5 A. Yes, I did.

6 Q. Are those contained in your notes today?

7 A. Yes, I have the report.

8 Q. Have you offered professional opinions as a
9 clinical psychologist in legal proceedings before
10 today?

11 A. Yes, I have.

12 Q. Okay. Tell us, when did you first see Herbert
13 Ross as a patient?

14 A. I saw Herbert Ross on April 13, 2011.

15 Q. And have you seen him since that date?

16 A. Yes, I have.

17 Q. Can you tell us approximately how many times
18 you've seen him as a patient, and with what
19 frequency?

20 A. I -- I have seen him, my initial treatment
21 session with him was on April 6 -- or September
22 6, 2011. And my most recent treatment session
23 with him was on September 23, 2014. I have seen
24 him approximately twice a month on average.

25 Q. For about the last three years or so?

1 A. Yes.

2 Q. Okay. So you've been actively participating in
3 his professional care as a clinical psychologist
4 during that time?

5 A. Yes, I have.

6 Q. When you first met with Herbert, did he give you
7 a history as to why he was there, why he was
8 seeing you?

9 A. Yes, he -- he did.

10 Q. Can you tell us briefly about that?

11 A. Herbert told me that since he -- he had been --
12 well, actually he was originally injured; injured
13 his back on June 29, 2009.

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

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

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

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

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

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

15 Q. Because of the physical --

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

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

1 depressed.

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

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

11 Q. All right. And he related all this to you in the
12 course of your evaluation with him?

13 A. Yes, he did.

14 Q. All right. Can you take us through the
15 evaluation that you performed and then your
16 course of treatment that you entered into with
17 him?

18 A. Sure. In all of these diagnostic evaluations, I
19 do, what we call a clinical interview. And
20 clinical interview forms the basis of a
21 psychological evaluation.

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

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

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

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

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

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

25 He described the four most problems as

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

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

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

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

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

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

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

14 Q. Can I interrupt you?

15 A. Yes.

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

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

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

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

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

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

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

1 Q. The physical requirement?

2 A. **The physical requirements. So as he had never --**
3 **talking about somebody in the army, coast guard,**
4 **police.**

5 Q. Right.

6 A. **So it's very much one type of functioning that**
7 **he's done professionally. And he's never -- he**
8 **knew nothing about anything else, so other**
9 **alternative types of ways to make a living.**

10 Q. During the course of your treatment with him over
11 the last three years, did he ever express a
12 desire to try to return to work?

13 A. **Many times. He -- he would hope that, you**
14 **know -- he -- he wanted to. His family,**
15 **particularly his wife, was worried about, you**
16 **know, what could happen if he would be reinjured,**
17 **because his back was vulnerable, and he would**
18 **have problems with his, you know, radiating pain**
19 **into the leg and difficulty with just prolonged**
20 **sitting or walking. And so it was something he**
21 **struggled with a lot, and --**

22 Q. Let me go back in time to your initial --

23 A. Sure.

24 Q. --- the initial evaluation in April. How long of
25 a meeting did you have with him? How long did

1 that initial evaluation take?

2 A. **I -- I met with him twice. I do evaluations like**
3 **this slowly. And it's not unusual for me to meet**
4 **twice with a person. My initial meeting is an**
5 **hour-and-a-half, so my second meeting must have**
6 **been an hour. So I did the evaluation, and I**
7 **asked him about prior psychological history.**
8 **He said that while he was exposed to a lot of**
9 **trauma, and that he -- you know, in his work in**
10 **the coast guard, dead bodies and things like**
11 **that, he didn't experience any post-traumatic**
12 **stress type of symptoms.**

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

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

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

1 Q. Doctor, was there any evidence of any prior
2 psychological injuries or treatment?

3 A. **I believe he saw a psychologist. Let's see,**
4 **there was no -- I don't believe there was any**
5 **treatment. If there was --**

6 Q. Did he see a psychologist, because a friend had
7 been killed on-duty?

8 A. **That's what I recall him saying that he had a**
9 **couple visits with someone, a colleague that had**
10 **been killed and --**

11 Q. Any record of any prior psychological diagnosis
12 or injuries or workers' compensation?

13 A. **Not that I'm aware. And not that he's -- no.**

14 Q. Okay. All right. Doctor, based upon a
15 reasonable degree of psychological probability,
16 did you reach a working diagnosis after that --
17 the two April 2011 evaluations?

18 A. I did.

19 Q. What was your diagnosis?

20 A. **Well, you know, as part of my evaluation, I also**
21 **gave some tests. I gave a MMPI, and I also gave**
22 **a Beck Depression Inventory. I --**

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

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

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

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

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

23 Q. Okay.

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

1 depressive disorder.

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

7 Q. And he met that?

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

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

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

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

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

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

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

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

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

17 A. Yes.

18 Q. You noted his affect or mood?

19 A. Yes.

20 Q. You would have performed a mental status
21 evaluation?

22 A. Yes.

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

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

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

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

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

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

15 A. I did both.

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

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

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

25 A. Yes.

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

3 A. Don't worry. Yeah.

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

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

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

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

24 Q. Right.

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

1 about how he will provide for his family.

2 Q. Have you had occasion to treat other police
3 officers?

4 A. Yes.

5 Q. Have you observed common traits or common culture
6 among these police officers?

7 A. Yes. I think of all the groups that I have
8 treated in 19 years of doing this, police
9 officers fall the far -- fall the hardest when it
10 comes to not being able to continue doing their
11 job for physical reasons.

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

16 So there's a lot of -- they are very
17 uncomfortable about expressing their emotions,
18 expressing feelings of -- of fear and sadness.
19 And it's more comfortable for them to express it
20 as anger.

21 Q. And to be tough?

22 A. And to be tough. They are also the most
23 non-adaptive types that I have ever come across.

24 Q. What does that mean?

25 A. In other words, their ego and their self-image is

1 so invested, entirely invested in being a wearer
2 of the badge, that really anything else is
3 unsatisfactory, it doesn't measure up. It's
4 less.

5 Q. Did Herbert tell you about socializing with other
6 police officers when he was injured, and whether
7 he was able to do that or not?

8 A. He had times where he did, but he felt kind
9 alienated. He -- there was a lot of shame. He
10 had, as I said, been injured in the past, and it
11 didn't take him out. So -- and he -- it's a very
12 high risk job, people get hurt. So he, you know,
13 he felt -- I mean, it was embarrassing for him.

14 Q. Doctor, your treatment over the past three years,
15 did that consist of -- of therapy sessions, or
16 what happens when he sees you, I guess is my
17 question?

18 A. He's always early to his appointments. And that
19 is interesting, because that doesn't usually
20 happen. But he's always early to his
21 appointments.

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

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

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

17 And for him, he felt like he was useless,
18 doing nothing. And it was hard for him to get a
19 sense of accomplishment of any kind when he
20 wasn't working.

21 Q. Since your treatment with him, have you noticed
22 an improvement?

23 A. I have. I've noticed -- as I said, adjustment
24 for police officers to not being able to do their
25 job, is very, very difficult. They have a bias

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

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

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

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

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

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

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

- 1 as a result of -- while he was working as a
- 2 police officer for the City of Cleveland?
- 3 A. **Yes.**
- 4 Q. Okay. Doctor, let me ask you, do you have a
- 5 professional opinion, based upon a reasonable
- 6 degree of psychological certainty, whether
- 7 Herbert Ross sustained a psychological or mental
- 8 health injury as a result of that workplace auto
- 9 accident of June 26, 2009?
- 10 A. **Yes.**
- 11 Q. What is your opinion?
- 12 A. **My opinion is that Herb developed depression as a**
- 13 **direct result as of the injuries he suffered on**
- 14 **June 26, 2009.**
- 15 Q. Would that specifically be depressive disorder,
- 16 not otherwise specified in your clinical
- 17 psychologist lingo?
- 18 A. **Yes.**
- 19 Q. Okay. Thank you, Doctor. I would like for you
- 20 to -- I would like to ask you a couple other
- 21 questions, and I'm almost done. The defendants
- 22 had Herbert examined by Dr. George Serna. You
- 23 are aware of that?
- 24 A. **Yes.**
- 25 Q. Have you been provided with a copy of Dr. Serna's

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

THE WITNESS: Thank you.

- - - -

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

34

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.

- - - -

36

(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.

- 1 Q. Okay. This particular test result did not
2 suggest that Mr. Ross had any psychological or
3 mental condition at all, did it?
- 4 A. **Yes. Yes. No, it did not suggest -- the MMPI**
5 **was within the normal range.**
- 6 Q. Okay.
- 7 A. **But it's important to notice that it said that he**
8 **attempted to present somewhat favorable**
9 **self-image, so it would be taken with a little**
10 **bit of a grain of salt.**
- 11 Q. All right. Further down on that page under
12 interpersonal relations, it describes -- the
13 report describes Mr. Ross as quite outgoing and
14 sociable. He has strong need to be around
15 others. He is gregarious and enjoys attention.
16 Personality characteristics related to social
17 introversion/extraversion tend to be stable over
18 time. This client is typically outgoing and his
19 sociable behavior is not likely to change if he
20 is retested at a later time, correct?
- 21 A. **Um-hmm.**
- 22 Q. Yes?
- 23 A. **Yes.**
- 24 Q. Thank you. Okay. If we turn to page 6 of that
25 report, under diagnostic conditions, again, the

- 1 report indicates his clinical profile is within
2 normal limits, no diagnostic considerations are
3 provided for individuals in this elevation range,
4 correct?
- 5 A. **Yes.**
- 6 Q. Thank you. And I believe towards the end of that
7 interpretive report -- well, I guess that was the
8 passage, his condition was not anticipated to
9 change if retested at a later time.
10 Now, Doctor, the Beck Test that you gave --
11 we'll strike that -- part of the evaluation of
12 the MMPI-2 Test is that -- my understanding is
13 it's given to individuals with known conditions;
14 is that correct?
- 15 A. **That the MMPI is given to individuals with known**
16 **conditions?**
- 17 Q. Correct.
- 18 A. **It could be given to anyone.**
- 19 Q. Okay. Well, as part of the value of the test,
20 part of the way it's used, that if a patient
21 answers similar to somebody with a known
22 condition, it's more likely that they also have
23 that condition; is that how that works?
- 24 A. **No. It's -- I mean, it can be used for -- for**
25 **diagnostic purposes. It can be -- I'm not quite**

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

- 1 A. **Yes.**
- 2 Q. -- does not have the same built-in scales for
3 testing reliability --
- 4 A. **No.**
- 5 Q. -- is that correct?
- 6 A. **No. It's much shorter. Very, very widely used**
7 **and accepted depression inventory.**
- 8 Q. Okay. And the -- the test that you actually gave
9 Mr. Ross, the one test is actually called Beck
10 Depression Inventory, correct?
- 11 A. **Yeah, Beck Depression Inventory 2.**
- 12 Q. Beck Depression Inventory 2, that's actually in
13 the title of the test?
- 14 A. **Yes.**
- 15 Q. And I've seen the test results for the tests that
16 Mr. Ross were given, and it appears that the
17 entirety of the test is composed of about 21
18 questions --
- 19 A. **Yes.**
- 20 Q. Is that correct? The -- do you know how many
21 questions are in the MMPI-2 Test?
- 22 A. **500 and -- oh, gosh. I'll tell you, 567.**
- 23 Q. All right. 567 questions with the MMPI-2.
24 All right. And you also indicated that the
25 -- the Beck Inventory is subject to possibly -- I

- 1 don't want to misuse your term, but may be
2 affected by pain condition?
- 3 **A. Yes.**
- 4 **Q. Something to that effect?**
- 5 **A. The scores can be elevated due to various**
6 **physical conditions.**
- 7 **Q. Okay. Now, the Beck Tests that you gave, were**
8 **indicative of severe depression; is that fair?**
- 9 **A. The score was in the severely depressed category.**
- 10 **Q. Okay. And you gave this Beck Test, the first one**
11 **I have is April 13 of 2011. Was that the same**
12 **day that Mr. Ross took the MMPI-2?**
- 13 **A. Oh, he would have taken that, date assessed, 5/9.**
14 **Well, I don't know if that's -- they were within**
15 **a month of each other. This MMPI-2 has date**
16 **assessed 5/9.**
- 17 **Q. Okay. You think that is the same day that he**
18 **took the test?**
- 19 **A. You know, it -- it's a very long test, and people**
20 **with pain don't sit real well and focus for that**
21 **long. So it could have been on a different day**
22 **that he took that.**
- 23 **Q. All right. So these are two very different test**
24 **results that we have. I mean, one indicating**
25 **severe depression, and the other indicating test**

- 1 results that are within normal limits; is that
2 fair?
- 3 **A. They are two very different tests by nature.**
4 **That -- that's the strength of the report, you**
5 **give a number of different tests combined with a**
6 **clinical interview, and no one piece of data**
7 **determines it. The clinical interview is the --**
8 **the key part of the evaluation.**
- 9 **Q. You indicated that your understanding today is**
10 **that Mr. Ross is pain-free?**
- 11 **A. His words, I could tell you his words were -- I**
12 **mean, he would have post-surgical pain. So, I**
13 **mean, for him the -- the fusion was -- exceeded**
14 **his exceptions, and -- okay. What he said was on**
15 **August 4, that immediate relief on all aspects.**
16 **So that was his -- his experience after the**
17 **fusion, was that he had immediate relief, so --**
- 18 **Q. And that fusion was --**
- 19 **A. I put in the words pain-free. He may not be**
20 **pain-free, but he had immediate relief on all**
21 **aspects.**
- 22 **Q. And he had the surgery when?**
- 23 **A. On May 7.**
- 24 **Q. So approximately four --**
- 25 **A. Three months --**

- 1 **Q. Three months?**
- 2 **A. -- was my first visit with him.**
- 3 **Q. Oh, you mean three months after the surgery?**
- 4 **A. Yeah.**
- 5 **Q. All right. And did he then relate any change in**
6 **his daily activities as a result of the surgery**
7 **that he had had?**
- 8 **A. Well, he was recovering. And he has to wear a**
9 **bone stimulator for a year. However, he is in**
10 **less pain.**
- 11 **Q. Did you feel that his symptoms of depression had**
12 **improved?**
- 13 **A. Yes. On August 4, I administered the Beck**
14 **Depression Inventory, again. And it was in the**
15 **moderate range, which indicates significant**
16 **psychological improvement from his scoring the**
17 **severe -- the severe range.**
- 18 **So, at least, just in looking at the Beck**
19 **Depression Inventory, there had been improvement**
20 **in the score. And, as noted, that Beck needs to**
21 **be taken with a grain of salt, because**
22 **discomfort, which would be natural**
23 **post-surgically, could be accounting for some**
24 **symptoms of, you know, difficulty sleeping or**
25 **fatigue.**

- 1 **Q. Were you given Dr. Serna's test results?**
- 2 **A. No, I -- he -- just -- just his report.**
- 3 **Q. Okay. You -- when we were discussing the**
4 **reliability scales that are built into the MMPI,**
5 **if those scales suggest that a patient is not**
6 **accurately answering; answering all questions**
7 **true, answering all questions false, whatever,**
8 **that obviously you would make the test results**
9 **invalid, correct?**
- 10 **A. You know, there is a number of different validity**
11 **indicators and reliability indicators. And the**
12 **number of those grows by the year.**
- 13 **You know, so the validity indicators can tell**
14 **you about the response style of the individual**
15 **taking the test. And how they answered, if you**
16 **compare the first part of it to the last part of**
17 **it, and you -- if you look at the frequency of**
18 **endorsed symptoms relative to various normative**
19 **group.**
- 20 **If it is a low frequency endorsement. Or the**
21 **-- yeah, there's one validity indicator that**
22 **reports on the -- the frequency of low frequency**
23 **endorsed items. So if you have a large number of**
24 **low frequency endorsed items, then that scale**
25 **would be elevated.**

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

1 similar at all to what they are telling me. And
 2 whether my clinical observation shows some kind
 3 of -- that the individual's behavior and
 4 presentation would be congruent with their
 5 reported symptoms.
 6 Q. In this case, you have not been provided with
 7 Dr. Serna's test results, correct?
 8 MR. BARBOUR: Objection.
 9 A. No, just what he wrote in the report.
 10 Q. Okay. So you don't know if those test results
 11 were suggestive of exaggeration?
 12 A. Yes, I do, because he said that in the report.
 13 MR. SCOTT: Okay. Thank you,
 14 Doctor. That's all I have.
 15 THE WITNESS: Okay.
 16 - - - -
 17 RE-EXAMINATION OF MARIAN M. CHATTERJEE, PH.D.
 18 BY MR. BARBOUR:
 19 Q. Doctor, a couple things. First of all, is there
 20 anything that counsel for the defendant brought
 21 up that causes you to change your opinion that
 22 you gave when I was asking you questions?
 23 A. No, it doesn't.
 24 Q. Doctor, as I understand it, you testified earlier
 25 that you would not rely or you cannot rely -- I

1 don't want to put words in your mouth -- solely
 2 on the results of a test to make a diagnosis in a
 3 clinical psychological setting?
 4 A. No. And clinical psychology, I can't ethically
 5 make a diagnosis on any individual as a result of
 6 my clinical interview alone. I cannot ethically
 7 make a diagnosis of an individual on the basis of
 8 a test alone.
 9 Q. And -- and is that pursuant to the American
 10 Psychological Association --
 11 A. Yes.
 12 Q. -- guidelines?
 13 A. Yes.
 14 Q. And that's your professional membership
 15 organization --
 16 A. Yes.
 17 Q. -- that sets rules that all of you try to live by
 18 in your profession?
 19 A. Yes, it is.
 20 Q. All right. Doctor, when I go see my internist,
 21 he could give me a blood test, and he could tell
 22 me that my cholesterol is too high.
 23 These MMPIs and these Beck Diagnostics,
 24 they're not that kind of test, are they? They
 25 are not a definitive answer to your psychological

1 --
 2 MR. SCOTT: Objection.
 3 Q. -- condition, or are they?
 4 A. No, there is no -- psychological conditions are
 5 not quantifiable. They -- there is no dipstick
 6 to measure how much depression a person has.
 7 And what is critical, I believe is to have a
 8 trained psychologist doing a very thorough
 9 clinical interview and mental status evaluation,
 10 as well as getting details on an individual's
 11 pre-incident functioning.
 12 In Mr. Ross' case, his preinjury functioning
 13 and his postinjury function with respect to
 14 behavior and psychological functioning. And as
 15 much corroborative data, in other words, ideally
 16 family reports, people think he's acting
 17 different.
 18 Is there any medical records from doctors
 19 showing that he is, in fact, experiencing a
 20 significant incident, physically, mentally. So,
 21 in other words, you for -- as a psychologist,
 22 there is no -- there is no way to quantify or to
 23 measure any psychological condition.
 24 And the strength of a diagnosis rests on
 25 having a very thorough clinical interview with a

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

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

9 A. Yes.

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

11 A. Yes.

12 Q. -- I think you testified?

13 A. Yes.

14 Q. And then you've testified that you've seen
15 Herbert since September 2011 up into September of
16 2014?

17 A. Yes.

18 Q. Twice a month, on average?

19 A. On average, yes.

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

21 A. Yes.

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

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

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

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

7 A. Yes, I did.

8 Q. I meant Herbert not Dr. Serna?

9 A. Yes.

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

12 A. Herb said he was in and out of there in less than
13 45 minutes. He was told that it would last
14 between two to four hours. He had just been
15 examined by another person a month before.

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

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

1 ever -- he ever felt that way.

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

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

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

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

1 MR. BARBOUR: Okay. Thank you,
2 Doctor.

3 MR. SCOTT: Nothing further.

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

7 THE WITNESS: I'll waive it.

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

11 MR. BARBOUR: Yes.

12 MR. SCOTT: Yes.

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

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

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

<p>1</p> <p>1 [4] - 1:16, 3:7, 5:16, 5:22 10 [1] - 53:21 106 [1] - 2:7 13 [2] - 9:14, 41:11 1332 [2] - 1:21, 53:20 17 [1] - 10:16 19 [2] - 6:16, 25:8 1994 [1] - 6:9 1995 [2] - 6:11, 6:15</p>	<p>48 [1] - 3:12</p> <p>5</p> <p>5 [1] - 3:7 5/9 [2] - 41:13, 41:16 50 [2] - 2:2, 49:20 500 [1] - 40:22 51 [1] - 28:21 55 [2] - 1:20, 53:20 567 [2] - 40:22, 40:23</p>	<p>act [4] - 15:22, 16:2, 16:3, 29:22 acting [1] - 48:16 action [3] - 30:7, 30:10, 53:14 actively [1] - 10:2 activities [2] - 21:14, 43:6 acts [2] - 15:25 actual [1] - 35:17 acute [1] - 51:20 adaptive [1] - 25:23 adjust [1] - 16:3 adjusting [1] - 15:24 Adjustment [1] - 7:4 adjustment [1] - 27:23 administer [1] - 53:6 administered [5] - 23:3, 23:5, 33:15, 39:25, 43:13 admitting [2] - 20:20, 20:21 adult [1] - 6:9 affect [8] - 13:4, 13:6, 13:9, 13:17, 22:18, 24:5, 51:16 affected [1] - 41:2 affiliated [1] - 53:14 aforementioned [1] - 53:11 afraid [1] - 27:1 afternoon [1] - 33:10 afterwards [1] - 11:2 age [1] - 4:3 agencies [2] - 6:23, 7:5 aggravated [1] - 10:17 aggravation [1] - 11:9 agitation [2] - 21:25, 24:19 aided [1] - 53:9 al [1] - 1:7 alienated [2] - 15:1, 26:9 allowed [1] - 15:8 almost [2] - 21:14, 31:21 alone [4] - 23:9, 45:9, 47:6, 47:8 alternative [1] - 17:9 American [2] - 6:12, 47:9 and's [1] - 39:14 anger [2] - 25:20, 27:5 answer [1] - 47:25 answered [4] - 39:15, 44:15, 50:23, 50:25 answering [5] - 34:6, 34:12, 44:6, 44:7</p>	<p>answers [1] - 38:21 anticipated [1] - 38:8 anxiety [2] - 39:9, 39:17 anxious [2] - 28:22, 29:7 APPEARANCES [1] - 2:1 appetite [1] - 21:21 appointments [2] - 26:18, 26:21 appropriate [1] - 51:14 approved [1] - 6:13 April [8] - 9:14, 9:21, 17:24, 19:17, 22:15, 34:21, 36:7, 41:11 army [3] - 14:13, 16:7, 17:3 aspects [3] - 13:18, 42:15, 42:21 assessed [2] - 41:13, 41:16 assessing [1] - 6:22 assist [2] - 33:18, 39:11 Associates [1] - 1:14 Association [2] - 6:13, 47:10 assume [1] - 32:3 assuming [1] - 32:10 attempted [2] - 10:15, 37:8 attend [1] - 7:9 attention [1] - 37:15 attitude [1] - 20:16 attorney [2] - 53:12, 53:13 Attorney [1] - 33:6 August [2] - 42:15, 43:13 authorized [1] - 53:5 auto [1] - 31:8 average [3] - 9:24, 49:18, 49:19 aware [3] - 19:13, 24:15, 31:23</p>	<p>30:5, 31:5, 32:12 basis [4] - 12:20, 23:9, 23:11, 47:7 Beachwood [1] - 1:15 became [2] - 11:25, 15:23 Beck [18] - 19:22, 19:23, 19:25, 23:3, 33:13, 33:24, 35:10, 38:10, 40:9, 40:11, 40:12, 40:25, 41:7, 41:10, 43:13, 43:18, 43:20, 47:23 becoming [1] - 14:15 began [1] - 23:20 begin [1] - 28:16 beginning [1] - 36:16 behalf [3] - 1:17, 2:4, 2:9 behavior [4] - 13:13, 37:19, 46:3, 48:14 behaviors [1] - 12:25 believes [1] - 29:15 between [2] - 30:14, 50:14 bias [1] - 27:25 big [1] - 14:7 bit [2] - 28:3, 37:10 black [1] - 27:11 blocks [1] - 15:7 blood [1] - 47:21 bodies [2] - 18:10, 18:22 body [1] - 13:3 bone [1] - 43:9 border [1] - 21:9 bothered [1] - 18:25 Boulevard [1] - 1:14 bounce [1] - 10:20 briefly [1] - 10:10 bring [1] - 14:22 brother [2] - 12:6, 12:7 brought [1] - 46:20 built [3] - 34:1, 40:2, 44:4 built-in [2] - 34:1, 40:2 Bureau [4] - 8:4, 8:7, 8:11, 8:25 BY [6] - 3:3, 3:4, 3:6, 4:10, 33:4, 46:18</p>
<p>2</p> <p>2 [5] - 3:8, 7:16, 7:20, 40:11, 40:12 20 [2] - 6:17, 53:17 2009 [6] - 10:13, 15:6, 30:23, 31:9, 31:14, 35:1 2011 [10] - 9:14, 9:22, 10:16, 19:17, 22:15, 34:21, 35:6, 36:7, 41:11, 49:15 2014 [4] - 1:16, 9:23, 29:9, 49:16 2016 [1] - 53:21 21 [1] - 40:17 216 [2] - 2:3, 2:8 216)664-0541 [1] - 1:22 216)664-5501 [1] - 1:22 23 [1] - 9:23 24100 [1] - 1:14 26 [2] - 31:9, 31:14 28(D) [1] - 53:15 29 [1] - 10:13</p>	<p>6</p> <p>6 [3] - 9:21, 9:22, 37:24 601 [1] - 2:7 664-2894 [1] - 2:8</p> <p>7</p> <p>7 [2] - 3:8, 42:23 771-8188 [1] - 2:3</p> <p>9</p> <p>920 [1] - 2:2</p>	<p>A</p> <p>A.D [1] - 53:17 ability [1] - 22:8 ablation [1] - 28:14 able [2] - 10:14, 10:15, 10:18, 10:20, 10:22, 11:4, 11:12, 11:18, 11:19, 11:25, 15:6, 16:11, 20:3, 25:10, 26:7, 27:24, 29:21, 30:10, 35:7, 35:11, 51:12 above-named [1] - 53:7 above-set [1] - 53:8 absence [2] - 23:2, 51:19 accept [1] - 28:16 accepted [1] - 40:7 accident [6] - 30:6, 30:22, 30:25, 31:9, 35:1, 51:6 accomplishment [1] - 27:19 accounting [1] - 43:23 accurately [2] - 34:7, 44:6</p>	<p>B</p> <p>bachelor's [1] - 7:10 badge [1] - 26:2 band [1] - 50:16 Barbour [1] - 2:2 BARBOUR [9] - 3:3, 3:6, 3:11, 4:10, 32:23, 46:8, 46:18, 52:1, 52:11 based [4] - 19:14,</p>	<p>C</p> <p>cancel [1] - 26:22 candidates [2] - 20:13, 20:14 cannot [3] - 23:8, 46:25, 47:6</p>
<p>3</p> <p>33 [1] - 3:4 36 [1] - 3:8 3:36 [1] - 1:15</p>				
<p>4</p> <p>4 [3] - 3:3, 42:15, 43:13 40 [1] - 49:20 400 [1] - 1:14 44113 [4] - 1:21, 2:3, 2:7, 53:20 44122 [1] - 1:15 45 [1] - 50:13 46 [2] - 3:6, 3:11</p>				

capable [1] - 39:14
capacity [1] - 14:19
car [2] - 30:22, 30:25
care [2] - 10:3, 27:15
career [1] - 16:8
cares [1] - 21:18
case [7] - 9:4, 23:13, 33:23, 34:16, 46:6, 48:12
CASE [1] - 1:5
Case [1] - 7:10
cases [1] - 6:20
category [1] - 41:9
causes [1] - 46:21
causing [1] - 30:17
cellphone [1] - 50:1
certainly [6] - 20:15, 31:6, 39:2, 39:14, 45:2, 49:20
certified [1] - 4:7
certify [2] - 53:6, 53:6
Chagrin [1] - 1:14
challenges [1] - 16:22
Chana [3] - 1:12, 53:5, 53:19
chance [1] - 28:7
change [4] - 37:19, 38:9, 43:5, 46:21
characteristics [1] - 37:16
characterized [1] - 21:4
Chatterjee [3] - 4:12, 33:5, 36:4
CHATTERJEE [8] - 1:11, 3:2, 3:4, 3:5, 4:3, 4:9, 33:3, 46:17
check [1] - 34:10
cholesterol [1] - 47:22
chores [2] - 11:20, 27:14
City [4] - 2:6, 31:2, 33:8, 50:4
CITY [1] - 1:7
Civil [2] - 4:5, 53:15
civil [1] - 6:20
CLEVELAND [2] - 1:7, 1:21
Cleveland [7] - 2:3, 2:6, 2:7, 31:2, 33:8, 53:16, 53:20
Cleveland's [1] - 50:5
client [1] - 37:18
client's [1] - 36:23
clinical [26] - 4:14, 6:4, 6:13, 9:9, 10:3, 12:19, 12:20, 12:22, 22:15, 23:5, 23:11, 31:16, 38:1, 39:13, 42:6, 42:7, 45:23,

46:2, 47:3, 47:4, 47:6, 48:9, 48:25, 51:14, 51:23
Clinical [2] - 6:8, 7:8
coast [3] - 14:14, 17:3, 18:10
colleague [1] - 19:9
com [1] - 29:8
combination [1] - 21:23
combined [1] - 42:5
comfortable [2] - 24:12, 25:19
coming [2] - 12:10, 13:23
commission [1] - 53:21
Commission [3] - 6:24, 8:10, 8:25
committed [1] - 30:2
COMMON [1] - 1:1
common [3] - 14:17, 25:5
compare [2] - 44:16, 45:16
compensation [3] - 6:24, 8:20, 19:12
Compensation [4] - 8:4, 8:8, 8:12, 8:25
complete [1] - 51:12
completed [1] - 6:12
composed [1] - 40:17
computer [2] - 50:22, 53:9
computer-aided [1] - 53:9
concentrate [1] - 22:8
concentrating [1] - 24:21
concentration [1] - 22:25
concern [1] - 27:5
concerning [1] - 6:1
concerns [1] - 24:18
conclusions [1] - 49:23
condition [9] - 32:22, 37:3, 38:8, 38:22, 38:23, 39:4, 41:2, 48:3, 48:23
conditions [7] - 7:2, 37:25, 38:13, 38:16, 39:8, 41:6, 48:4
congruent [1] - 46:4
conjunction [1] - 39:12
consider [2] - 24:8, 51:13
considerations [1] - 38:2

considered [1] - 23:10
consist [1] - 26:15
consistent [1] - 32:5
constantly [1] - 15:10
consultation [1] - 5:8
contact [1] - 13:3
contained [1] - 9:6
content [1] - 13:12
continue [2] - 10:15, 25:10
contract [1] - 53:14
cop [2] - 28:2, 29:15
cope [1] - 18:14
copy [2] - 31:25, 35:21
correct [20] - 22:16, 33:15, 33:23, 34:21, 35:1, 36:11, 36:14, 36:24, 37:20, 38:4, 38:14, 38:17, 39:10, 39:18, 40:5, 40:10, 40:20, 44:9, 45:4, 46:7
CORRIGAN [1] - 1:5
corroborative [3] - 48:15, 49:2, 49:3
counsel [4] - 1:17, 46:20, 52:9, 53:12
County [1] - 53:3
COUNTY [1] - 1:2
couple [5] - 11:17, 19:9, 31:20, 35:11, 46:19
course [6] - 5:4, 12:12, 12:16, 17:10, 23:18, 35:13
COURT [1] - 1:1
court [1] - 53:14
cramping [1] - 14:3
criteria [3] - 20:25, 21:11, 22:12
critical [2] - 45:14, 48:7
culture [1] - 25:5
current [2] - 6:14, 7:25
curriculum [1] - 7:22
Cuyahoga [1] - 53:3
CUYAHOGA [1] - 1:2
CV-13-815257 [1] - 1:5

D

daily [1] - 43:6
data [3] - 42:6, 48:15, 49:3
date [5] - 7:25, 9:15, 41:13, 41:15, 53:11
daughter [2] - 21:19, 50:16
days [1] - 49:10

dead [2] - 18:10, 18:22
deal [3] - 11:19, 16:9, 22:2
death [1] - 22:9
December [1] - 6:11
defendant [1] - 46:20
Defendants [2] - 1:8, 2:9
defendants [1] - 31:21
Defendants' [4] - 3:8, 36:1, 36:5, 36:10
defense [3] - 6:25, 8:24, 14:18
defensive [1] - 20:15
defined [1] - 53:15
definitive [1] - 47:25
Degree [1] - 7:13
degree [3] - 19:15, 31:6, 32:13
demographic [1] - 50:20
denominator [1] - 14:17
Department [1] - 2:6
deposed [1] - 4:7
deposition [5] - 1:10, 5:13, 53:7, 53:8, 53:11
depositions [1] - 53:6
depressed [4] - 12:1, 21:4, 21:12, 41:9
Depression [9] - 19:22, 19:23, 19:25, 23:4, 40:10, 40:11, 40:12, 43:14, 43:19
depression [17] - 11:5, 18:19, 19:24, 21:11, 21:22, 22:4, 22:12, 31:12, 39:9, 39:16, 39:22, 40:7, 41:8, 41:25, 43:11, 48:6, 51:9
depressive [6] - 20:3, 20:22, 21:1, 21:2, 21:24, 31:15
described [3] - 13:25, 30:5, 34:17
describes [2] - 37:12, 37:13
description [1] - 13:21
designed [1] - 39:3
desire [1] - 17:12
desperately [1] - 26:24
details [1] - 48:10
detect [3] - 39:7, 39:8, 45:6
detective [3] - 10:24, 15:10, 18:24
determine [1] - 13:14

determined [1] - 13:11
determines [1] - 42:7
developed [1] - 31:12
diagnosis [16] - 13:20, 19:11, 19:16, 19:19, 21:3, 23:7, 23:9, 23:11, 23:17, 33:19, 39:12, 47:2, 47:5, 47:7, 48:24, 51:25
diagnostic [4] - 12:18, 37:25, 38:2, 38:25
Diagnostics [1] - 47:23
difference [1] - 28:25
different [10] - 25:13, 28:14, 28:17, 33:17, 41:21, 41:23, 42:3, 42:5, 44:10, 48:17
differs [2] - 33:24, 33:25
difficult [2] - 10:25, 27:25
difficulty [8] - 14:2, 14:3, 17:19, 24:21, 30:19, 43:24
diminished [2] - 21:13, 22:8
dipstick [1] - 48:5
direct [2] - 31:13, 51:18
direction [1] - 53:10
disability [5] - 6:22, 8:6, 8:13, 8:19
Disability [1] - 7:4
discharged [1] - 16:6
discomfort [1] - 43:22
discuss [1] - 15:16
discussing [1] - 44:3
disks [1] - 29:3
disorder [5] - 21:1, 21:2, 21:3, 31:15, 51:19
disorders [1] - 39:9
distinguish [1] - 20:7
distress [2] - 11:5, 14:6
disturbance [1] - 51:20
Doctor [16] - 7:19, 8:2, 19:1, 19:14, 22:13, 31:4, 31:19, 32:23, 33:11, 38:10, 45:1, 46:14, 46:19, 46:24, 49:6, 52:2
doctor [4] - 5:15, 11:10, 26:14, 47:20
doctorate [1] - 7:14
Doctorate [2] - 6:8, 7:8
doctors [1] - 48:18

doctors' [1] - 49:4
document [1] - 7:21
done [2] - 17:7, 31:21
down [3] - 11:12, 28:10, 37:11
Dr [16] - 11:10, 31:22, 31:25, 32:3, 32:10, 33:5, 36:4, 44:1, 46:7, 50:4, 50:8, 50:11, 50:20, 51:3, 51:4
driving [2] - 14:2
due [8] - 14:4, 20:1, 20:3, 20:4, 20:8, 21:20, 21:23, 41:5
duly [2] - 4:6, 53:7
during [3] - 10:4, 17:10, 45:23
duty [2] - 16:18, 19:7
Duty [1] - 7:3

E

early [2] - 26:18, 26:20
easier [1] - 26:25
easy [1] - 30:1
eck [1] - 39:24
education [1] - 6:4
effect [1] - 41:4
ego [2] - 25:25, 28:3
eight [1] - 21:6
either [1] - 27:12
elevated [2] - 41:5, 44:25
elevation [1] - 38:3
embarrassing [1] - 26:13
emotional [1] - 14:6
emotionally [1] - 18:14
emotions [1] - 25:17
employee [2] - 53:12, 53:13
employers' [1] - 49:4
end [2] - 38:6, 51:9
ended [1] - 12:10
endorsed [3] - 44:18, 44:23, 44:24
endorsement [1] - 44:20
endorsing [1] - 45:25
energy [1] - 22:3
enforcement [1] - 14:18
English [1] - 7:12
enjoyable [1] - 21:16
enjoyed [1] - 16:9
enjoys [1] - 37:15
enter [1] - 23:18

entered [1] - 12:16
entirely [1] - 26:1
entirety [2] - 40:17, 52:6
episode [1] - 29:4
episodes [1] - 27:2
especially [1] - 15:12
Esq [3] - 2:2, 2:5, 2:6
essence [1] - 32:8
et [1] - 1:7
ethically [3] - 23:8, 47:4, 47:6
evaluated [1] - 4:22
evaluating [1] - 45:3
evaluation [19] - 5:8, 8:22, 12:12, 12:15, 12:21, 17:24, 18:1, 18:6, 19:20, 22:21, 22:24, 33:12, 38:11, 42:8, 48:9, 49:1, 49:8, 51:15, 51:22
evaluations [11] - 5:1, 7:3, 8:6, 8:10, 8:13, 8:19, 9:2, 12:18, 18:2, 19:17, 22:15
eventually [1] - 11:5
evidence [3] - 19:1, 22:10, 51:20
exacerbation [1] - 28:11
exactly [1] - 30:8
exaggeration [4] - 45:4, 45:6, 45:10, 46:11
examination [2] - 1:11, 4:5
EXAMINATION [6] - 3:2, 3:3, 3:5, 4:9, 33:3, 46:17
examinations [1] - 8:17
examined [2] - 31:22, 50:15
examining [1] - 16:16
exceeded [1] - 42:13
exceptions [1] - 42:14
Exhibit [10] - 3:7, 3:8, 3:8, 5:16, 5:22, 7:16, 7:20, 36:1, 36:5, 36:10
expect [3] - 39:21, 45:21, 51:11
expectations [1] - 14:21
experience [3] - 18:11, 24:10, 42:16
experienced [2] - 21:20, 21:22
experiencing [1] - 48:19

expires [1] - 53:21
exposed [2] - 18:8, 18:22
express [4] - 16:10, 17:11, 25:19, 27:4
expressed [1] - 24:17
expressing [2] - 25:17, 25:18
expression [2] - 13:5, 13:8
expressions [1] - 13:16
expressive [1] - 13:9
extent [1] - 20:22
eye [1] - 13:3
eyes [1] - 12:23

F

fact [2] - 34:22, 48:19
facts [1] - 32:10
fair [6] - 30:6, 33:19, 34:7, 39:4, 41:8, 42:2
faking [2] - 32:9, 32:15
fall [2] - 25:9
false [3] - 34:13, 44:7, 50:25
family [9] - 12:8, 14:11, 14:23, 17:14, 25:1, 27:1, 27:3, 48:16, 49:3
far [1] - 25:9
fast [2] - 15:22, 50:19
fatigue [2] - 22:2, 43:25
favorable [3] - 20:11, 20:19, 37:8
FAX [1] - 1:22
fear [1] - 25:18
February [2] - 10:16, 35:6
feelings [2] - 22:5, 25:18
felt [13] - 11:6, 14:25, 15:16, 16:10, 20:17, 21:8, 26:8, 26:13, 27:6, 27:17, 34:20, 51:1
few [7] - 7:4, 12:6, 23:20, 26:22, 27:4, 49:10, 50:24
file [3] - 5:16, 35:16, 35:20
filing [1] - 52:10
finally [1] - 35:6
financially [1] - 53:13
findings [1] - 6:1

finish [1] - 50:19
fire [1] - 7:6
firm [1] - 53:14
first [11] - 4:6, 9:12, 10:6, 14:9, 29:21, 41:10, 43:2, 44:16, 46:19, 50:24, 53:7
Fitness [1] - 7:3
five [4] - 21:6, 21:10, 36:19, 51:5
focus [3] - 27:9, 27:10, 41:20
focused [1] - 6:20
focusing [1] - 6:8
follow [1] - 29:23
followed [1] - 14:13
following [1] - 30:3
follows [1] - 4:8
football [1] - 50:17
foremost [1] - 14:10
forensic [1] - 6:20
forgot [1] - 7:7
forms [1] - 12:20
forth [1] - 53:8
four [4] - 13:25, 14:12, 42:24, 50:14
fragile [1] - 25:13
free [4] - 29:7, 42:10, 42:19, 42:20
frequency [8] - 9:19, 28:13, 34:15, 44:17, 44:20, 44:22, 44:24
friend [1] - 19:6
friends [1] - 21:19
frightened [1] - 27:3
front [3] - 5:12, 35:22, 50:22
full [4] - 13:9, 16:18, 16:24, 20:21
full-duty [1] - 16:18
function [5] - 11:7, 15:8, 18:15, 18:25, 48:13
functioning [5] - 17:6, 39:6, 48:11, 48:12, 48:14
functions [1] - 23:1
fusion [7] - 28:25, 29:1, 29:2, 29:12, 42:13, 42:17, 42:18
fusions [1] - 29:6
future [2] - 24:25, 28:23

G

game [1] - 50:17
games [1] - 21:18
gauging [1] - 34:5

George [1] - 31:22
given [9] - 11:16, 20:18, 22:23, 38:13, 38:15, 38:18, 40:16, 44:1, 53:10
gosh [2] - 28:20, 40:22
graduated [1] - 6:6
grain [2] - 37:10, 43:21
grand [1] - 28:4
great [5] - 11:5, 11:19, 15:18, 16:9, 22:2
greatly [1] - 29:11
gregarious [1] - 37:15
grew [1] - 14:8
group [1] - 44:19
groups [3] - 25:7, 25:14
grows [1] - 44:12
guard [3] - 14:14, 17:3, 18:10
guarded [1] - 20:15
guess [5] - 12:7, 14:16, 15:1, 26:16, 38:7
guidelines [1] - 47:12

H

half [3] - 18:5, 32:21, 49:7
hand [3] - 7:19, 35:21, 53:16
handed [1] - 36:9
handing [1] - 36:4
hard [4] - 15:12, 16:3, 27:18, 34:8
hardest [1] - 25:9
head [1] - 14:9
health [3] - 8:14, 31:8, 32:15
hearing [1] - 45:20
helping [1] - 28:18
herb [1] - 50:12
Herb [1] - 31:12
HERBERT [1] - 1:3
Herbert [20] - 4:18, 6:1, 9:4, 9:12, 9:14, 10:6, 10:11, 23:13, 24:6, 24:7, 26:5, 30:6, 31:7, 31:22, 32:8, 32:14, 49:15, 50:4, 50:8, 50:10
hereby [1] - 53:6
hereinafter [1] - 4:7
hereunto [1] - 53:16
herniated [1] - 29:3
high [3] - 20:8, 26:12,

<p>47:22 himself [4] - 10:22, 14:20, 24:16, 29:4 history [6] - 10:7, 15:3, 15:4, 18:7, 34:24, 49:2 hmm [1] - 37:21 honorably [1] - 16:6 hooked [1] - 15:11 hope [1] - 17:13 hour [4] - 18:5, 18:6, 49:7, 49:10 hour-and-a-half [2] - 18:5, 49:7 hours [1] - 50:14 house [2] - 11:20, 11:24 household [1] - 14:9 hurt [2] - 26:12, 28:6</p>	<p>38:1, 43:15 indicating [2] - 41:24, 41:25 indicative [2] - 41:8, 45:10 indicator [1] - 44:21 indicators [3] - 44:11, 44:13 indices [1] - 45:15 individual [6] - 13:21, 24:8, 39:14, 44:14, 47:5, 47:7 individual's [3] - 45:13, 46:3, 48:10 individuals [3] - 38:3, 38:13, 38:15 Industrial [3] - 6:24, 8:10, 8:24 inflated [1] - 20:1 information [1] - 49:3 initial [8] - 9:20, 17:22, 17:24, 18:1, 18:4, 33:12, 34:25, 49:7 injured [7] - 8:3, 10:12, 10:19, 18:21, 26:6, 26:10 injuries [5] - 8:14, 19:2, 19:12, 31:13, 35:2 injury [17] - 7:2, 10:17, 10:21, 11:16, 15:4, 15:5, 15:6, 15:24, 16:1, 18:14, 28:12, 30:9, 30:22, 31:8, 32:9, 32:16, 34:25 insomnia [1] - 21:22 instructions [2] - 29:24, 50:23 interest [2] - 21:13, 21:15 interested [1] - 53:13 interesting [1] - 26:19 internal [1] - 13:17 internist [1] - 47:20 internship [1] - 6:13 interpersonal [2] - 27:9, 37:12 interpretive [8] - 36:11, 36:16, 36:19, 36:22, 38:7, 39:18 interrupt [1] - 15:14 interview [14] - 12:19, 12:20, 12:22, 22:16, 23:12, 39:13, 42:6, 42:7, 45:23, 47:6, 48:9, 48:25, 51:14, 51:23 introversion/ extraversion [1] - 37:17</p>	<p>invalid [1] - 44:9 Inventory [10] - 19:22, 19:23, 19:25, 23:4, 40:10, 40:11, 40:12, 40:25, 43:14, 43:19 inventory [1] - 40:7 invested [2] - 26:1 involve [2] - 8:14, 28:18 involved [2] - 12:8, 33:12 involving [1] - 6:21 irritability [1] - 24:19 irritable [1] - 27:2 issues [1] - 6:21 items [2] - 44:23, 44:24</p> <p style="text-align: center;">J</p> <p>JK [1] - 1:20 job [13] - 11:4, 11:13, 11:19, 14:21, 16:5, 16:25, 25:11, 26:12, 27:13, 27:14, 27:25, 30:20, 51:9 Joseph [2] - 2:5, 33:5 JR [1] - 1:3 JUDGE [1] - 1:5 judgment [1] - 23:3 July [1] - 6:14 June [4] - 10:13, 30:23, 31:9, 31:14</p> <p style="text-align: center;">K</p> <p>keep [2] - 5:1, 11:20 keeping [1] - 20:4 kept [1] - 27:7 key [1] - 42:8 kill [1] - 45:21 killed [2] - 19:7, 19:10 kind [14] - 12:24, 13:1, 13:23, 14:12, 14:18, 15:12, 24:9, 24:20, 26:8, 27:19, 28:10, 34:8, 46:2, 47:24 kinds [4] - 14:5, 33:17, 45:19, 45:24 knowing [1] - 35:13 known [3] - 38:13, 38:15, 38:21 knows [1] - 29:23</p> <p style="text-align: center;">L</p> <p>Lakeside [1] - 2:7 large [2] - 11:12,</p>	<p>44:23 last [6] - 9:25, 17:11, 23:23, 44:16, 50:13, 51:8 law [1] - 14:18 Law [1] - 2:6 lawful [1] - 4:3 least [1] - 43:18 leg [2] - 14:2, 17:19 legal [1] - 9:9 less [3] - 26:4, 43:10, 50:12 level [1] - 19:24 licensed [2] - 4:15, 6:10 life [1] - 51:21 likely [3] - 34:10, 37:19, 38:22 limitations [1] - 28:22 limits [2] - 38:2, 42:1 lingo [1] - 31:17 lisa [1] - 2:6 Lisa [1] - 33:6 listening [1] - 13:12 lists [1] - 45:20 live [3] - 26:25, 47:17, 50:21 living [1] - 17:9 location [1] - 6:14 long-term [1] - 23:1 look [3] - 22:25, 44:17, 45:24 looking [1] - 43:18 lookout [1] - 45:3 losing [1] - 27:1 loss [2] - 21:20, 22:2 lost [1] - 21:15 loved [1] - 16:5 low [4] - 34:15, 44:20, 44:22, 44:24 lumbar [2] - 29:2, 29:12</p> <p style="text-align: center;">M</p> <p>Mack [2] - 2:6, 33:6 major [7] - 18:23, 20:25, 21:2, 21:11, 21:22, 22:3, 22:12 majoring [1] - 7:11 malingering [3] - 32:8, 32:14, 32:18 man [6] - 11:24, 14:7, 14:8, 24:9, 30:6, 30:10 manage [1] - 11:4 managed [1] - 18:14 March [1] - 53:21 Margareten [3] - 1:12,</p>	<p>53:5, 53:19 Marian [1] - 4:12 MARIAN [8] - 1:10, 3:2, 3:4, 3:5, 4:3, 4:9, 33:3, 46:17 mark [3] - 5:16, 35:21, 35:24 Mark [1] - 2:2 marked [5] - 5:22, 7:16, 7:20, 36:1, 36:5 markedly [1] - 21:13 marriage [2] - 27:7, 51:6 Master's [1] - 7:12 matter [1] - 32:4 matters [1] - 8:21 mean [15] - 18:20, 20:6, 21:9, 25:24, 26:13, 29:8, 29:13, 35:17, 38:24, 39:1, 41:24, 42:12, 42:13, 43:3, 49:25 meaning [2] - 12:23, 13:7 means [1] - 53:9 meant [1] - 50:8 measure [4] - 20:6, 26:3, 48:6, 48:23 measures [1] - 28:2 medical [2] - 8:16, 48:18 medication [2] - 10:23, 15:8 meet [6] - 14:21, 16:21, 16:24, 18:3, 21:11, 50:6 meeting [4] - 17:25, 18:4, 18:5, 22:1 membership [1] - 47:14 memory [2] - 22:25, 23:1 mental [11] - 8:14, 22:20, 22:24, 31:7, 32:15, 37:3, 39:4, 48:9, 49:1, 51:15, 51:22 mentally [1] - 48:20 mention [1] - 51:16 mentioned [2] - 12:3, 51:3 met [8] - 10:6, 18:2, 20:25, 21:7, 21:8, 21:9, 21:10, 22:11 might [1] - 33:18 minded [1] - 24:8 mine [1] - 36:17 minimum [1] - 21:10 minutes [3] - 12:6,</p>
--	---	---	---	---

50:13, 51:5
miss [1] - 26:23
misuse [1] - 41:1
MMI [1] - 36:6
MMP1-2 [1] - 34:18
MMPI [8] - 19:21,
 20:10, 37:4, 38:15,
 39:7, 44:4, 45:25,
 51:12
MMPI-2 [12] - 33:13,
 33:23, 35:10, 35:15,
 36:6, 38:12, 39:3,
 40:21, 40:23, 41:12,
 41:15, 45:8
MMPIs [1] - 47:23
moderate [1] - 43:15
month [5] - 9:24,
 23:23, 41:15, 49:18,
 50:15
months [6] - 11:17,
 23:20, 35:11, 42:25,
 43:1, 43:3
mood [8] - 13:10,
 13:14, 13:17, 21:3,
 21:4, 21:12, 22:18,
 51:16
most [7] - 9:22, 13:25,
 20:10, 21:4, 21:12,
 25:12, 25:22
motivated [1] - 24:14
motor [1] - 34:25
mouth [1] - 47:1
MR [17] - 3:3, 3:4, 3:6,
 3:11, 3:12, 4:10,
 32:23, 33:4, 35:24,
 46:8, 46:13, 46:18,
 48:2, 52:1, 52:3,
 52:11, 52:12
multiple [1] - 4:20
must [1] - 18:5

N

name [2] - 4:11, 33:5
named [1] - 53:7
narcotic [1] - 10:23
narcotics [2] - 11:2,
 11:3
natural [1] - 43:22
nature [2] - 42:3,
 45:22
near [1] - 5:7
nearly [2] - 21:5, 21:14
need [1] - 37:14
needed [1] - 50:19
needs [2] - 21:5, 43:20
never [11] - 15:24,
 16:5, 17:2, 17:7,
 24:7, 24:9, 28:4,

30:11, 32:20, 51:3
next [1] - 33:7
nine [1] - 22:7
NO [1] - 1:5
non [1] - 25:23
non-adaptive [1] -
 25:23
none [1] - 51:21
normal [5] - 5:4,
 36:23, 37:5, 38:2,
 42:1
normally [2] - 11:20,
 21:16
normative [1] - 44:18
Notary [3] - 1:12, 53:5,
 53:19
note [1] - 29:8
noted [2] - 22:18,
 43:20
notes [1] - 9:6
nothing [4] - 17:8,
 27:18, 52:3, 53:8
notice [4] - 1:16, 8:2,
 37:7, 53:12
noticed [2] - 27:21,
 27:23
noticing [1] - 14:6
number [13] - 10:19,
 21:10, 28:14, 39:3,
 39:8, 39:12, 42:5,
 44:10, 44:12, 44:23,
 45:14, 49:5, 50:1
numbness [3] - 14:1,
 14:3, 30:19

O

oaths [1] - 53:6
OBJECTION [1] - 3:10
objection [1] - 46:8
Objection [1] - 48:2
objective [1] - 45:17
observation [2] -
 13:11, 46:2
observations [4] -
 12:23, 24:18, 45:17,
 49:22
observed [1] - 25:5
observing [1] - 13:13
obtaining [1] - 7:7
obvious [1] - 22:5
obviously [1] - 44:8
occasion [1] - 25:2
occurred [1] - 30:25
October [1] - 1:16
OF [5] - 1:1, 1:7, 4:9,
 33:3, 46:17
offer [1] - 32:7
offered [1] - 9:8

office [1] - 53:16
officer [10] - 11:23,
 14:15, 15:17, 15:19,
 16:11, 27:13, 28:5,
 30:13, 30:14, 31:2
officers [7] - 20:11,
 20:13, 25:3, 25:6,
 25:9, 26:6, 27:24
OHIO [2] - 1:2, 1:21
Ohio [15] - 1:13, 1:15,
 2:3, 2:7, 4:15, 6:11,
 8:3, 8:7, 8:11, 53:2,
 53:5, 53:16, 53:19,
 53:20
old [1] - 28:21
on-duty [1] - 19:7
once [1] - 24:22
one [15] - 6:12, 17:6,
 21:5, 24:1, 28:8,
 29:3, 29:14, 33:24,
 40:9, 41:10, 41:24,
 42:6, 44:21, 45:2,
 51:2
one-page [1] - 51:2
one-year [1] - 6:12
OPERS [1] - 7:5
opinion [8] - 22:1,
 31:5, 31:11, 31:12,
 32:7, 32:12, 32:17,
 46:21
opinions [1] - 9:8
opportunity [2] - 33:9,
 50:5
opposed [1] - 20:9
order [1] - 36:17
organization [1] -
 47:15
originally [1] - 10:12
origins [1] - 18:20
otherwise [1] - 31:16
outgoing [2] - 37:13,
 37:18
outside [1] - 14:1
outward [3] - 13:5,
 13:7, 13:16
own [1] - 8:20
Oxycodone [1] - 15:9

P

p.m [1] - 1:15
packet [1] - 36:9
page [4] - 36:19,
 37:11, 37:24, 51:2
pain [16] - 11:19, 14:3,
 14:4, 17:18, 20:2,
 21:23, 29:7, 29:11,
 30:17, 41:2, 41:20,
 42:10, 42:12, 42:19,

42:20, 43:10
pain-free [4] - 29:7,
 42:10, 42:19, 42:20
pains [1] - 20:4
paper [2] - 51:2, 51:12
part [13] - 9:1, 19:20,
 33:11, 33:20, 35:16,
 36:9, 36:16, 38:11,
 38:19, 38:20, 42:8,
 44:16
participating [1] -
 10:2
particular [3] - 34:6,
 34:17, 37:1
particularly [1] - 17:15
parties [1] - 53:13
party [1] - 52:9
passage [1] - 38:8
past [4] - 10:20, 18:21,
 26:10, 26:14
Patel [1] - 11:10
patience [3] - 29:16,
 29:18, 29:19
PATIENCE [1] - 29:20
patient [8] - 4:18,
 4:20, 9:13, 9:18,
 34:6, 38:20, 44:5,
 45:3
patients [2] - 6:19,
 8:20
patterns [1] - 36:20
pencil [2] - 51:3, 51:13
people [5] - 24:20,
 26:12, 28:19, 41:19,
 48:16
perform [1] - 8:6
performance [1] -
 45:13
performed [3] - 12:15,
 22:20, 49:6
period [1] - 35:3
person [11] - 11:1,
 11:12, 13:1, 13:14,
 14:12, 15:1, 18:4,
 39:22, 45:18, 48:6,
 50:15
personality [3] -
 15:20, 37:16, 39:5
PH.D [8] - 1:11, 3:2,
 3:4, 3:5, 4:3, 4:9,
 33:3, 46:17
Ph.D [1] - 7:8
physical [16] - 11:15,
 13:22, 13:23, 14:16,
 15:7, 15:21, 17:1,
 17:2, 20:2, 20:8,
 25:11, 28:11, 28:21,
 30:9, 35:2, 41:6
physically [2] - 14:20,
 48:20

physicians [1] - 16:16
piece [1] - 42:6
place [1] - 53:11
Plaintiff [4] - 1:4, 1:18,
 2:4, 4:4
plaintiff [2] - 6:25,
 8:24
Plaintiff's [5] - 3:7,
 3:8, 5:22, 7:16, 7:20
play [1] - 21:18
PLEAS [1] - 1:1
point [1] - 29:9
police [20] - 7:6,
 11:23, 14:15, 15:17,
 15:18, 16:11, 17:4,
 20:10, 20:13, 20:14,
 25:2, 25:6, 25:8,
 26:6, 27:13, 27:24,
 28:5, 30:13, 30:14,
 31:2
poor [1] - 21:20
population [1] - 6:9
position [2] - 15:22,
 30:12
positive [1] - 20:16
possible [5] - 21:6,
 39:19, 39:23, 45:6,
 49:4
possibly [4] - 28:4,
 28:7, 28:17, 40:25
post [3] - 18:11,
 42:12, 43:23
post-surgical [1] -
 42:12
post-surgically [1] -
 43:23
post-traumatic [1] -
 18:11
postinjury [1] - 48:13
posture [1] - 13:4
potential [1] - 50:3
practice [2] - 6:10,
 6:16
practicing [1] - 6:14
pre [1] - 48:11
pre-incident [1] -
 48:11
predominant [1] -
 13:18
preinjury [1] - 48:12
preoccupation [1] -
 24:23
preparation [1] - 5:13
prepared [1] - 5:25
presence [2] - 20:1,
 23:2
present [1] - 37:8
presentation [2] -
 13:1, 46:4
presented [1] - 20:11

presenting [1] - 20:19
pressure [1] - 21:13
pretty [1] - 28:12
pride [1] - 15:18
primarily [1] - 6:20
private [1] - 6:16
privilege [1] - 33:7
probability [2] - 19:15, 32:13
problem [1] - 15:23
problems [4] - 13:24, 13:25, 17:18, 18:23
Procedure [1] - 4:6
proceeding [1] - 33:8
proceedings [1] - 9:9
profession [3] - 4:13, 5:5, 47:18
professional [8] - 9:8, 10:3, 25:14, 31:5, 32:7, 32:12, 32:17, 47:14
professionally [1] - 17:7
profile [5] - 20:18, 34:18, 36:23, 38:1, 39:5
projecting [1] - 20:16
prolonged [1] - 17:19
promised [1] - 14:22
property [1] - 27:15
protective [1] - 14:18
provide [5] - 7:1, 8:19, 14:10, 14:23, 25:1
provided [8] - 4:5, 4:24, 31:25, 32:6, 38:3, 46:6
provider [1] - 11:24
provides [1] - 39:5
psychological [26] - 4:24, 6:21, 7:1, 8:14, 12:21, 18:7, 19:2, 19:11, 19:15, 20:9, 21:2, 24:11, 31:6, 31:7, 32:9, 32:13, 32:15, 37:2, 43:16, 47:3, 47:25, 48:4, 48:14, 48:23, 49:5, 51:25
Psychological [2] - 6:12, 47:10
psychologically [2] - 24:8, 25:13
psychologist [18] - 4:14, 4:16, 6:5, 9:9, 10:3, 12:9, 12:24, 13:20, 19:3, 19:6, 23:6, 23:8, 24:13, 31:17, 32:18, 33:18, 48:8, 48:21
Psychology [3] - 6:8,

7:9, 7:13
psychology [3] - 6:10, 7:11, 47:4
psychotic [1] - 51:20
Public [5] - 1:12, 2:2, 53:5, 53:19, 53:20
PUBLIC [1] - 1:20
pulling [1] - 24:20
purpose [2] - 4:4, 27:10
purposes [4] - 5:23, 7:17, 36:2, 38:25
pursuant [3] - 1:16, 47:9, 53:11
put [4] - 5:18, 42:19, 47:1, 50:22

Q

qualify [1] - 22:1
quantifiable [1] - 48:5
quantify [1] - 48:22
questions [12] - 31:21, 32:24, 34:6, 34:13, 40:18, 40:21, 40:23, 44:6, 44:7, 46:22, 50:21
quite [2] - 37:13, 38:25

R

racing [1] - 14:4
radiating [1] - 17:18
radicular [1] - 30:18
radio [1] - 28:13
rage [2] - 27:2, 27:5
ran [1] - 24:22
randomly [1] - 34:11
range [5] - 36:24, 37:5, 38:3, 43:15, 43:17
rE [2] - 3:5, 46:17
rE-EXAMINATION [2] - 3:5, 46:17
reach [2] - 19:16, 23:7
reached [1] - 23:16
reaching [1] - 49:23
read [1] - 50:24
reader [1] - 51:11
real [2] - 16:13, 41:20
really [10] - 15:20, 16:15, 20:17, 26:2, 26:24, 27:15, 28:1, 28:15, 29:16, 33:17
reason [1] - 13:23
reasonable [3] - 19:15, 31:5, 32:12

reasoning [1] - 23:3
reasons [1] - 25:11
recent [1] - 9:22
recommendations [1] - 30:3
recommended [1] - 16:15
record [5] - 4:2, 11:10, 19:11, 52:14, 53:10
records [4] - 5:1, 5:4, 5:7, 48:18
recovering [1] - 43:8
reduced [1] - 53:9
reflected [1] - 39:17
regardless [1] - 8:23
reinjured [1] - 17:16
relate [1] - 43:5
related [2] - 12:11, 37:16
relations [1] - 37:12
relative [3] - 44:18, 53:12, 53:13
relevant [1] - 51:18
reliability [6] - 34:1, 34:3, 34:5, 40:3, 44:4, 44:11
relief [4] - 28:15, 42:15, 42:17, 42:20
rely [4] - 23:6, 45:15, 46:25
remember [1] - 24:22
report [18] - 9:7, 19:24, 32:1, 32:6, 36:11, 36:16, 36:19, 36:22, 37:13, 37:25, 38:1, 38:7, 39:18, 42:4, 44:2, 45:16, 46:9, 46:12
reported [4] - 24:21, 34:15, 46:5, 51:21
REPORTING [1] - 1:20
reporting [4] - 34:14, 45:18, 45:22, 53:14
reports [8] - 7:4, 9:1, 9:4, 44:22, 48:16, 49:3, 49:4
representing [1] - 33:7
reprimanded [1] - 16:6
request [3] - 8:3, 8:7, 50:5
requirement [1] - 17:1
requirements [2] - 16:25, 17:2
res [1] - 7:22
Reserve [1] - 7:11
respect [1] - 48:13
responding [1] - 34:11

response [2] - 34:11, 44:14
responsibility [1] - 14:10
restrain [1] - 11:13
restricted [1] - 13:6
rests [1] - 48:24
result [10] - 22:14, 23:16, 30:22, 31:1, 31:8, 31:13, 34:25, 37:1, 43:6, 47:5
results [11] - 23:6, 35:15, 40:15, 41:24, 42:1, 44:1, 44:8, 45:7, 46:7, 46:10, 47:2
resume [2] - 7:23, 7:24
retested [2] - 37:20, 38:9
retirement [1] - 7:5
return [7] - 11:18, 16:11, 16:17, 17:12, 30:19, 35:7, 35:12
Return [1] - 7:3
review [1] - 52:5
reviewed [1] - 5:12
risk [2] - 16:19, 26:12
risky [1] - 11:14
road [2] - 27:2, 27:5
Room [1] - 2:7
ross [6] - 32:17, 33:12, 35:11, 36:7, 37:2, 40:9
ROSS [1] - 1:3
Ross [15] - 4:18, 6:1, 9:13, 9:14, 31:7, 32:8, 34:17, 34:21, 34:24, 35:18, 36:22, 37:13, 40:16, 41:12, 42:10
Ross' [2] - 9:4, 48:12
Rule [1] - 53:15
Rules [1] - 4:5
rules [1] - 47:17
run [1] - 11:13

S

sadness [1] - 25:18
salt [2] - 37:10, 43:21
saw [8] - 9:14, 11:16, 19:3, 21:25, 23:21, 50:4
scale [1] - 44:24
scales [5] - 34:2, 34:4, 40:2, 44:4, 44:5
school [2] - 7:9, 50:17
score [2] - 41:9, 43:20

scores [4] - 20:1, 20:6, 35:18, 41:5
scoring [1] - 43:16
Scott [2] - 2:5, 33:5
SCOTT [8] - 3:4, 3:12, 33:4, 35:24, 46:13, 48:2, 52:3, 52:12
screwed [1] - 18:17
seal [1] - 53:16
seasoned [1] - 32:18
seated [1] - 33:6
Seattle [1] - 6:7
second [2] - 18:5, 36:18
secondary [1] - 7:2
see [15] - 4:18, 6:19, 8:3, 9:12, 12:9, 12:10, 19:3, 19:6, 20:12, 21:21, 22:10, 45:24, 47:20, 51:23
seeing [4] - 8:9, 10:8, 12:25, 24:13
sees [1] - 26:16
self [5] - 11:22, 20:12, 20:20, 25:25, 37:9
self-image [4] - 20:12, 20:20, 25:25, 37:9
self-worth [1] - 11:22
sense [3] - 11:22, 14:24, 27:19
September [5] - 9:21, 9:23, 29:9, 49:15
Serna [10] - 31:22, 32:3, 32:10, 50:4, 50:8, 50:11, 50:20, 51:3, 51:4
Serna's [3] - 31:25, 44:1, 46:7
session [2] - 9:21, 9:22
sessions [1] - 26:15
set [2] - 53:8, 53:16
sets [1] - 47:17
setting [1] - 47:3
seven [1] - 51:5
several [1] - 23:22
severe [5] - 19:24, 41:8, 41:25, 43:17
severely [1] - 41:9
shame [2] - 11:5, 26:9
short [2] - 22:25, 24:19
short-term [1] - 22:25
shorter [1] - 40:6
showed [1] - 45:18
showing [1] - 48:19
shows [2] - 20:19, 46:2
significant [3] - 28:13, 43:15, 48:20

similar [2] - 38:21, 46:1
single [2] - 24:1, 45:15
sit [1] - 41:20
sitting [1] - 17:20
six [1] - 14:13
skills [1] - 27:10
sleep [1] - 20:3
sleeping [2] - 14:3, 43:24
slightly [1] - 36:17
slowly [1] - 18:3
smartest [1] - 32:19
sociable [2] - 37:14, 37:19
social [1] - 37:16
socializing [2] - 21:19, 26:5
solely [2] - 23:6, 47:1
someone [3] - 11:2, 19:9, 34:10
somewhat [1] - 37:8
sort [7] - 14:17, 15:19, 18:19, 21:9, 28:9, 33:25, 50:21
source [1] - 11:4
southern [1] - 14:7
specific [1] - 50:23
specifically [1] - 31:15
specified [1] - 31:16
speech [4] - 13:2, 13:12, 51:17
speed [1] - 51:11
spend [1] - 21:18
squad [1] - 10:23
Square [2] - 2:2, 53:20
SQUARE [1] - 1:20
SS [1] - 53:2
stable [4] - 13:17, 16:8, 37:17
start [1] - 18:17
started [2] - 18:15, 29:5
State [6] - 1:13, 4:15, 6:10, 53:2, 53:5, 53:19
state [2] - 6:23, 7:5
status [6] - 22:20, 22:24, 48:9, 49:1, 51:15, 51:22
stenotypy [1] - 53:9
still [1] - 28:19
stimulator [1] - 43:9
stipulations [2] - 1:17, 53:12
stoplight [1] - 24:22
stream [1] - 13:2
strength [2] - 42:4, 48:24

stress [1] - 18:12
strike [1] - 38:11
strong [1] - 37:14
struggled [1] - 17:21
struggling [2] - 16:13, 16:22
stuff [1] - 18:22
style [1] - 44:14
sub [2] - 34:2, 34:4
sub-scales [2] - 34:2, 34:4
subject [1] - 40:25
subjective [1] - 45:16
successful [2] - 29:14, 29:22
suffered [2] - 31:13, 39:16
suffering [1] - 39:22
suggest [4] - 37:2, 37:4, 39:16, 44:5
suggesting [1] - 51:18
suggestive [2] - 12:5, 46:11
suicidal [3] - 12:5, 23:1, 50:2
suicide [2] - 22:9, 51:7
Suite [3] - 1:14, 2:2, 53:20
SUITE [1] - 1:21
suited [1] - 15:19
summarize [1] - 24:5
surgeon [1] - 29:5
surgeon's [1] - 29:23
surgery [3] - 42:22, 43:3, 43:6
surgical [1] - 42:12
surgically [1] - 43:23
suspects [1] - 11:13
sustained [2] - 30:21, 31:7
sworn [2] - 4:6, 53:7
symptom [4] - 21:21, 22:2, 22:3, 22:6
symptomatic [1] - 36:20
symptoms [18] - 18:12, 20:7, 20:8, 20:22, 20:24, 21:6, 28:11, 29:11, 30:18, 34:14, 43:11, 43:24, 44:18, 45:4, 45:7, 45:11, 45:25, 46:5
systems [1] - 7:5

T

talks [1] - 51:17
technology [1] - 53:10
temper [1] - 24:19

tend [1] - 37:17
term [3] - 22:25, 23:1, 41:1
Test [10] - 33:15, 35:10, 35:15, 36:6, 38:10, 38:12, 39:24, 40:21, 41:10
test [38] - 23:9, 33:12, 33:24, 34:1, 34:17, 34:20, 36:14, 37:1, 38:19, 39:3, 39:15, 40:8, 40:9, 40:13, 40:15, 40:17, 41:18, 41:19, 41:23, 41:25, 44:1, 44:8, 44:15, 45:7, 45:12, 45:13, 45:15, 45:18, 46:7, 46:10, 47:2, 47:8, 47:21, 47:24, 51:3, 51:13
testified [6] - 23:21, 33:11, 46:24, 49:6, 49:12, 49:14
testify [3] - 32:4, 32:5, 53:7
testimony [2] - 32:11, 53:10
testing [1] - 40:3
tests [11] - 19:21, 22:23, 23:5, 23:7, 23:12, 33:17, 39:13, 40:15, 42:3, 42:5, 49:5
Tests [1] - 41:7
texting [1] - 12:2
THE [8] - 1:1, 4:1, 33:1, 46:15, 52:4, 52:7, 52:8, 52:13
therapy [2] - 15:7, 26:15
thereabouts [2] - 10:17, 23:24
thereafter [1] - 35:7
Thereupon [3] - 5:22, 7:16, 36:1
thigh [1] - 14:1
thinking [2] - 16:20, 27:12
thorough [4] - 23:11, 48:8, 48:25, 49:1
thoughts [7] - 12:5, 14:4, 20:4, 21:24, 22:9, 24:25, 45:21
three [8] - 9:25, 17:11, 23:23, 26:14, 32:21, 42:25, 43:1, 43:3
three-and-a-half [1] - 32:21
title [1] - 40:13
today [5] - 5:10, 9:6,

9:10, 42:9, 49:24
together [1] - 33:6
took [7] - 15:18, 24:11, 34:18, 34:21, 41:12, 41:18, 41:22
tools [2] - 33:21, 33:22
top [1] - 5:18
topic [1] - 51:18
total [1] - 51:5
tough [2] - 25:21, 25:22
towards [1] - 38:6
traditional [1] - 24:9
trained [2] - 12:24, 48:8
training [1] - 6:4
traits [1] - 25:5
transcribed [1] - 53:9
trauma [1] - 18:9
traumatic [1] - 18:11
treat [1] - 25:2
treated [1] - 25:8
treating [1] - 32:21
treatment [17] - 4:24, 5:2, 5:25, 7:1, 9:20, 9:22, 10:14, 12:16, 15:5, 17:10, 19:2, 19:5, 23:18, 23:20, 24:5, 26:14, 27:21
tremendous [1] - 15:23
tremendously [1] - 29:13
trial [1] - 32:4
trick [1] - 32:20
tried [2] - 28:13, 28:14
true [5] - 32:10, 34:13, 44:7, 50:25, 53:10
truth [3] - 53:8, 53:8
truthfully [1] - 34:7
try [3] - 17:12, 32:5, 47:17
trying [1] - 35:4
turn [2] - 36:19, 37:24
twice [5] - 9:24, 18:2, 18:4, 23:22, 49:18
two [9] - 13:18, 19:17, 22:11, 22:14, 29:2, 33:17, 41:23, 42:3, 50:14
type [6] - 6:19, 11:1, 13:14, 14:19, 17:6, 18:12
types [2] - 17:9, 25:23
typical [1] - 20:10
typically [2] - 37:18, 39:20

U

ultimately [1] - 16:23
um-hmm [1] - 37:21
unable [1] - 14:20
uncertainties [1] - 28:20
uncomfortable [1] - 25:17
under [5] - 36:20, 37:11, 37:25, 53:10, 53:14
undergraduate [1] - 7:10
underlying [1] - 13:10
unethical [1] - 23:10
University [3] - 6:6, 7:11, 7:13
unsatisfactory [1] - 26:3
unusual [1] - 18:3
up [15] - 5:18, 7:25, 11:20, 11:23, 12:6, 12:10, 14:8, 20:5, 22:14, 26:3, 28:2, 28:10, 29:9, 46:21, 49:15
up-to-date [1] - 7:25
upset [1] - 11:8
useless [1] - 27:17
uselessness [1] - 14:25
utterly [1] - 14:25

V

valid [5] - 20:18, 34:18, 34:20, 34:22, 36:13
validity [5] - 34:2, 34:4, 44:10, 44:13, 44:21
value [1] - 38:19
various [5] - 6:21, 7:2, 34:2, 41:5, 44:18
vary [1] - 13:9
vehicle [1] - 35:1
verbal/nonverbal [1] - 12:25
vice [4] - 10:23, 10:24, 15:10, 18:24
Vicodin [4] - 11:7, 18:15, 18:17, 18:25
video [2] - 21:18, 52:10
VIDEOGRAPHER [4] - 4:1, 52:4, 52:8, 52:13

videotape [1] - 52:5 Videotaped [1] - 1:10 virtually [1] - 8:22 visit [3] - 23:19, 43:2, 50:10 visits [2] - 19:9, 24:2 vitae [1] - 7:22 voiced [1] - 49:23 voices [1] - 45:20 vs [1] - 1:5 vulnerable [1] - 17:17 W	world [2] - 24:11, 32:19 worried [4] - 15:11, 17:15, 24:25, 50:2 worry [1] - 24:3 worrying [1] - 24:25 worth [1] - 11:22 worthlessness [2] - 14:24, 22:5 wrapped [1] - 11:23 write [2] - 9:1, 9:4 writing [1] - 53:9 written [2] - 9:1, 22:23 wrote [1] - 46:9 WWW.JARKUB.COM [1] - 1:23 Y
waive [3] - 52:6, 52:7, 52:9 walk [1] - 30:18 walking [1] - 17:20 wants [3] - 28:8, 30:12, 30:19 Washington [3] - 6:7, 7:14 ways [2] - 17:9, 34:9 wear [1] - 43:8 wearer [1] - 26:1 Wednesday [1] - 1:16 weight [1] - 21:20 Weinstein [1] - 1:13 Western [1] - 7:10 wet [1] - 29:4 WHEREOF [1] - 53:16 white [1] - 27:11 whole [2] - 11:22, 53:8 widely [1] - 40:6 wife [7] - 12:2, 12:7, 12:8, 17:15, 24:17, 27:3, 50:18 wimp [1] - 28:7 withdrawal [2] - 24:20, 27:6 withdrew [2] - 27:7, 27:8 WITNESS [4] - 33:1, 46:15, 52:7, 53:16 witness [2] - 53:7, 53:11 wonder [1] - 35:20 words [11] - 15:2, 20:2, 25:25, 34:12, 42:11, 42:19, 47:1, 48:15, 48:21, 50:24 workers [1] - 8:3 workers' [2] - 6:23, 19:12 Workers' [5] - 8:4, 8:7, 8:11, 8:20, 8:25 workplace [1] - 31:8 works [2] - 15:21, 38:23	year [5] - 6:12, 8:9, 23:22, 43:9, 44:12 years [11] - 6:17, 9:25, 14:13, 17:11, 23:23, 25:8, 26:14, 28:21, 32:21 Z
	zero [1] - 13:19