THE COURT REPORTER

MR. B

JUAN F. MARTINEZ,
Testing this,
Plaintiff(s),

v. Case No:

THE CITY OF NEW YORK AND MTA 720729/2020
BUS COMPANY,
Defendant(s).

---

undefined

WITNESS:	MARTHA ROSARIO
DATE:	Wednesday, February 21, 2024
START TIME:	2:09 p.m.
END TIME:	2:58 p.m.
REMOTE LOCATION:	Remote Legal platform
REPORTER:	Kimberly Jones
JOB NO.:	23605

A P P E A R A N C E S

SULLIVAN & BRILL, LLC
110 East 59th Street, Floor 23
New York, New York 10022
By: JAMES HEALY, ESQ., ESQUIRE
James.healy@sulllivanbrill.com
Appearing for Plaintiff, JUAN F. MARTINEZ

ARMIENTI, DEBELLIS & RHODEN, LLP
39 Broadway, Room 520
New York, New York 10006
By: MICHAEL TANCREDI, ESQ., ESQUIRE
mtancredi@adrllp.com
Appearing for Defendant, THE CITY OF NEW YORK AND MTA BUS COMPANY

ALSO PRESENT:
test

I N D E X O F T E S T I M O N Y

EXAMINATION OF MARTHA ROSARIO: PAGE

By Attorney 1

By Attorney 2

By Attorney 1

I N D E X O F E X H I B I T S

(one of three parentheticals)

EXHIBIT DESCRIPTION PAGE

<PLEASE CHOOSE ONE PARENTHETICAL and enter under heading:
(none marked)
(available for download)
(retained by counsel)

If one or more exhibits are marked, INDEX OF EXHIBITS should be on its own page.

If no exhibits are marked, use the (none marked) parenthetical and put INDEX OF EXHIBITS on the same page as INDEX OF TESTIMONY.>

I N D E X O F R E Q U E S T S

DESCRIPTION	PAGE	LINE

<If no requests are made, delete this page from the transcript.>

FEDERAL STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED by and between the attorneys for the respective parties that the presence of the Referee be waived;

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to form, are reserved until the time of trial;

IT IS FURTHER STIPULATED AND AGREED that this deposition may be utilized for all purposes as provided by the Federal Rules of Civil Procedure;

AND FURTHER STIPULATED AND AGREED that all rights provided to all parties by the Federal Rules of Civil Procedure shall not be deemed waived and the appropriate sections of the Federal Rules of Civil Procedure shall be controlling with respect thereto.

FEDERAL REMOTE STIPULATIONS

IT IS HEREBY STIPULATED, by and between the attorneys of record for all parties to the above-entitled action, that:

Pursuant to Rule 30(b)(4) of the Federal Rules of Civil Procedure, this deposition will be conducted by remote videoconference with the oath being administered remotely and a court reporter creating an accurate written record; that, if necessary, the parties agree that each witness can be identified with picture identification;

No attorney, nor any party or witness, shall capture any still photographs, nor record, by video or audio, any part of these deposition proceedings;

Each attorney agrees to instruct their witness that there is to be no communication with anyone outside of the identified and participating group, by chat, text, email, or other means during the deposition;

There shall be no other person in the room with the witness during their deposition;

Any phone or electronic device in the room

with a witness shall be identified and not read, referred to, or otherwise used during the witness' deposition, unless agreed to by all counsel on record.

NEW YORK STIPULATIONS

IT IS HEREBY STIPULATED, by and between the attorneys for the respective parties hereto, that:

All rights provided by the CPLR and Part 221 of the Uniform Rules for the Conduct of Depositions, including the right to object to any questions, except as to form, or to move to strike any testimony at this examination is reserved; and in addition, the failure to object to any question or to move to strike any testimony at this examination shall not be a bar or waiver to make such motion at, and is reserved to, the trial of this action.

This deposition may be sworn to by the witness being examined before a Notary Public other than the Notary Public before whom this examination was begun, but the failure to do so or to return the original of this deposition to counsel, shall not be deemed a waiver of the rights provided by Rule 3116 of the CPLR, and shall be controlled thereby.

NEW YORK REMOTE STIPULATIONS

IT IS HEREBY STIPULATED, by and between the attorneys of record for all parties to the above-entitled action that:

Pursuant to Rule 3113(d) of the CPLR, this deposition will be conducted by remote videoconference with the oath being administered remotely and a court reporter creating an accurate written record; that, if necessary, the parties agree that each witness can be identified with picture identification;

No attorney, nor any party or witness, shall capture any still photographs, nor record, by video or audio, any part of these deposition proceedings;

Each attorney agrees to instruct their witness that there is to be no communication with anyone outside of the identified and participating group, by chat, text, email, or other means during the deposition;

There shall be no other person in the room with the witness during their deposition;

Any phone or electronic device in the room with a witness shall be identified and not read, referred to, or otherwise used during the witness' deposition, unless

agreed to by all counsel on record.

Each deposition taken hereunder shall be usable under the provisions of CPLR 3117 (Use of Depositions).

P R O C E E D I N G S

THE REPORTER: Good afternoon. We are now on the record. Today's date is February 20th, 2024, and the time is approximately 1:00 p.m., Eastern Standard Time.

My name is Anna Landreth and I'm the officer designated by Remote Legal, 11 Broadway, Suite 468, New York, New York, to take the record of this proceeding.

This is the deposition of Dr. Scott Bender taken in the matter of Dillon versus Newell, et al., Case Number CL21000344-00, filed in Virginia the -- in the Circuit Court for the Fauquier County.

Would all counsel please identify themselves for the record, their firm, and who they represent starting with the noticing attorney.

MR. LADUCA: Kenneth LaDuca, for the plaintiff, Caroline Dillon, firm is Price Benowitz.

MR. KING: Jason King, for the defendants, I'm with the firm of Franklin&Prokopik.

THE REPORTER: Thank you.

This deposition is being taken remotely

on behalf of the plaintiffs and is being conducted pursuant to the procedural rules and laws of the state which governs this matter.

As such, all parties agree to these means of capturing the official record, which may include recording by audio and/or audiovisual means, and agree not to oppose admission of this proceeding on the basis of the personnel or method by which this testimony in this proceeding was captured.

Do the parties so stipulate?

MR. LADUCA: Yes.

MR. KING: Yes.

THE REPORTER: I will now swear in the witness.

Will the witness please state and spell their name for the record?

DR. BENDER: Scott Bender, S-C-O-T-T, B-E-N-D-E-R.

THE REPORTER: Please raise your right hand.

Do you swear or affirm that the testimony you shall give today in this proceeding will be the truth, the whole truth, and nothing but the truth?

DR. BENDER: I do.

WHEREUPON,

S C O T T B E N D E R

having been called as a witness, being duly sworn by the notary public present, testified as follows:

THE REPORTER: Counsel, you may begin.

EXAMINATION

BY MR. LADUCA:

Q Good afternoon, Dr. Bender. We just met off the record. My name is Kenny LaDuca. I represent Caroline Dillon in this case. You've already stated your full name. Can you just state your business address for the record?

A Yes. I'm at 1230 Cedars Court, Suite 108 in Charlottesville, Virginia.

Q What is your current email address?

A S-, as in Sam, B-, as in boy, the number 4-, Q-, as in queen, K-, as in king, @virginia.edu.

Q Okay. Your office is on the University of Virginia campus, correct?

A It is. I mean, it's a satellite clinic. It's part of the university, but it's not right in the hospital proper.

Q All right. Do you have any papers with you today?

A Yes.

Q What do you have with you?

A I've got my chart from the assessment.
Q Do you have your actual report?
A Yes.
Q Okay. Do you have your CV?
A No.
Q Any other documents?
A No. Just all the things related to the -- the assessment.
Q Okay. And that would include your testing data?
A Yes.
Q Okay. Other than this program, do you have any other programs open in your computer currently?
A No.
Q You've been deposed before, correct?
A Yes.
Q Let's go over the general instructions with you again. I'm here today to hear what you're going to say at trial. There may be objections from time to time. You can defer to Mr. King as to those objections. I understand he's not your counsel, but he is paying you.

Clearly, we have a court reporter, so try not to talk over one another, head nods, uh-uh, Uh-huh, doesn't work. If you need a break at any point, let me

know. I do think this is going to go a little bit. You're a prolific writer, so -- I've read quite a few of your articles in the last couple days, so I have some questions on that.

If you don't understand one of my questions, I won't -- you won't offend me. Let me know. I'll try and reframe it so that you understand. But if you do answer a question, I'm going to assume that you understood it; is that fair?

A Sure.

Q Is there any reason you cannot give full and honest testimony today?

A No.

Q Are you on any medications that would affect cognition or understanding?

A No.

Q You understand we're here today to discuss a motor vehicle which Plaintiff alleges resulted in injuries, correct?

A Yes.

Q What was the date of that collision?

A August -- August of 2019. August 9th.

Q And where did that collision occur?

A In Fauquier County, I believe.

Q Okay. Do you have any understanding of how

that collision occurred?

A Yes.

Q And what is that understanding?

A That Ms. Dillon was stopped at a light and was struck from behind by -- by a vehicle.

Q Okay. Have you ever seen photos of the damage to the vehicles involved in the collision?

A I don't believe so.

Q Okay. Do you have any idea as to mechanism of injury?

A Do I have any -- any idea of mechanism of injury? I have ideas about that. Yes.

Q Okay. What is your understanding of the mechanism of injury in this case? And I understand multiple injuries have been alleged. So any injuries that were relevant to your evaluation?

A Well, there's a claim of concussion and pain and psychological disturbance from the accident.

Q Okay. In terms of the concussion, do you have an understanding of the allegation as to the mechanism of injury involved with that?

A Yes.

Q And what is your understanding?

A That she -- that the concussion caused a physical change of -- of motion in the car that was

translated to her brain.

Q Layman's terms, she was put forward and whipped back, correct?

A Yes. Something like that.

Q Right. The brain inside of her head moved around and caused the disturbance, correct?

A That's right.

Q Okay. So anytime I refer to "the incident," I'm referring to the collision. Prior to this case, did you have any understanding as to who Caroline Dillon was?

A No.

Q And as we've discussed, she is the plaintiff in this case. In preparation for today, have you reviewed any materials?

A Yes.

Q What did you review?

A My report, Dr. Hebda's report, the -- I'm not sure what it's called, but it's a designation, I guess. The plaintiff's designation, the defendant's designation, and then a rebuttal, I believe.

Q Okay. What about any medical records?

A I did not review any medical records recently.

Q Okay. Any deposition transcripts?

A No.

Q No. Any --

MR. KING: Ken, are you -- I'm sorry. Are you asking did he review deposition transcript ever or to get ready for the deposition?

MR. LADUCA: To get ready for today. I'll ask him about generally in a -- in a little bit when we get to his report.

BY MR. LADUCA:

Q What about any discovery responses?

A Not that I recall. No. Oh, certainly not lately. No.

Q Okay. Other than Dr. Hebda's initial report and the rebuttal report, did you review any other expert reports in preparation for today?

A Expert reports? I just received -- I'm not sure how you say her name, but Trachman, I think.

Q Susan Trachman.

A Just recently received that.

Q Okay.

A And -- go ahead.

Q Any other expert reports other than Dr. Trachman?

A No.

Q Okay. What time did Mr. King get there today?

A At about 12:35, 12:40.

Q Prior to his arrival today, when is the last time you spoke to him or anyone from his firm?

A Yesterday.

Q And who'd you speak with?

A With him.

Q For how long?

A Maybe 20 minutes, 30 minutes.

Q Just tell me generally about that conversation.

A It was sort of a logistic conversation, I guess, to remind me that this is what was happening. He asked me a little bit about what he -- what I thought I was going to say, basically. That's about it.

Q Did you review any documents during that conversation?

A No.

Q Okay. And did he tell you what opinions he expected to hear from you today?

A No.

Q Did he tell you what Plaintiff's argument in this case would be?

A No.

Q Did he tell you how to answer any specific questions?

A No.

Q Prior to the conversation yesterday, when is the last time you spoke to anyone from that law firm about this case?

A I'm not sure actually.

Q Okay. And I'm sure there were some logistics of getting the deposition set up, but do you remember the last time you had a substantive conversation with anyone from that law firm prior to yesterday about this case?

A No.

Q Certainly you would've had a conversation in the context of writing the report, correct?

A Yeah. Due -- you know, due dates or -- or hoped timelines, things like that.

Q In the process of writing your report, did you make any edits after conversations with Mr. King's firm?

A No.

Q Okay. Do you have a fee schedule for your medical legal work?

A Yes.

Q All right. So I don't have it. So can you just give me the breakdown of what you charge for different aspects of medical legal work, whether it be reviewing records, writing reports, depositions, testifying at trial?

A It's -- it's all the same. It's $400 per hour.

Q Okay. How much time have you spent working on this case?

A I don't know, actually. I would guess it's near -- near 20 hours.

Q You've billed for your work on this case, correct?

A Yes.

Q Do you know how much?

A No, I don't -- I don't know if we've submitted anything yet.

Q Okay. To the extent there is an invoice or billing that has occurred, I'd ask that you just provide it to Mr. King so he can provide it to me. Okay?

A Yes.

MR. LADUCA: All right. If technology works, I'm going to pull up what you've definitely seen before. It has been pre-marked as Exhibit 1, and the court reporter can just call it Exhibit 1.

BY MR. LADUCA:

Q Do you recognize this document?

A Yes.

Q And what is that?

A That's my CV.

Q I don't know if you can tell, I will scroll to the bottom, but is this your most recent CV?

A I can't really tell, but it's -- it's close. If it's not, then no problem.

Q Okay. All right. You are a neuropsychologist, correct?

A Yes.

Q What is neuropsychology?

A It's basically the -- the study of brain and behavioral relationships.

Q Okay. And as a neuropsychologist, tell me generally what you do.

A We see all sorts of patients who present with cognitive and emotional problems usually, at least, and they can -- those -- those problems can, like I said, can stem from all sorts of different conditions, but we -- we focus on assessing symptoms as objectively as possible, so we use tests in addition to our clinical -- or our clinical interview.

Q Okay. Do you hold yourself out as an expert in any other type medicine?

A No.

Q Do you need a license to practice medicine as a neuropsychologist?

A We need a license to practice psychology, to

practice neuropsychology. Yes.

Q And where are you licensed?

A Virginia, Louisiana, and I think I have temporary licenses in -- in various states, and I'm also a member of PSYPACT.

Q My next question was, what is PSYPACT?

A It's -- it's a, kind of a reciprocity program across states, so that if you're licensed somewhere and then go through their procedure for -- for this membership, you'll be recognized as licensed in these other states too.

Q Basically, allows you to practice in states where you aren't necessarily licensed, correct?

A Or hadn't been licensed before then. Yeah.

Q Sure. Are you board certified in anything?

A Yes. In clinical neuropsychology.

Q When is the last time you needed a recertification?

A I haven't needed one yet.

Q When is that up?

A I don't know.

Q You're not a neurologist, correct?

A No, I'm not.

Q Okay. Not a neurosurgeon, correct?

A Correct.

Q Not an orthopedic doctor, correct?
A That's correct.
Q Never performed a surgery, correct?
A No.
Q You are also not a psychiatrist, correct?
A That's correct.
Q You are not a medical doctor, correct?
A Correct.
Q Are you actively treating patients in a clinical setting where you see them more than once?
A On occasion. It's usually still in an evaluation context.
Q Okay. So for the most part, you're doing a one-time neuropsychological evaluation and then sending them on their way for whatever treatment they may need from a different provider, correct?
A That's right. I -- I used to do a lot of rehab work and therapy as well, but I haven't done that for quite some time.
Q Okay. Do you currently have any hospital privileges?
A Yes.
Q Where?
A At the University of Virginia health system.
Q Okay. Have you ever held privileges for any

other facility or network?

A No. Oh, I apologize. I -- I did at Martha Jefferson Psychiatric. Though there may have been some contract that allowed us to have privileges from UVA transfer there. I'm not sure how that worked.

Q Sure. Have you ever had hospital privileges suspended or revoked for any reason?

A No.

Q You know, these questions are coming. Have you ever had any adverse actions against your licensures?

A No.

Q Have you ever had any complaints made against you to any medical board?

A No.

Q Have you ever been sued for malpractice?

A No.

Q Have you ever been convicted of a felony or a crime involving moral turpitude like dishonesty?

A No.

Q Have you ever had any problems with substance abuse?

A No.

Q When did you first begin performing legal reviews?

A Approximately 2005 or '06.
Q So we're going on almost 20 years?
A Yes.
Q How many depositions have you done since you began serving as an expert?
A Several dozen.
Q Over 100?
A I don't think so.
Q How many trials have you actually had to go into the courtroom and testify or remote testify for a trial?
A Well, fewer -- fewer than I've been deposed. Just a handful, I think.
Q You think less than 10?
A Probably, yeah.
Q Okay. And kind of broadening the scope a little bit, not just your depositions, but how many cases since you began serving as an expert do you think you've worked on?
A That's over -- that's over 100.
Q Okay. Do you think it's several hundred or do you think it's probably between 100 and 200?
A Probably between 100 and 200.
Q Okay. Do you know your breakdown of work between plaintiff and defense on those cases?

A It's probably about 70/30 for the defense and -- and in civil cases, I do, well, quite a bit of criminal work too. It's probably about the same, 70/30 for the defendant in criminal cases.

Q All right. So on the civil side of things, 70/30 for the defendant, would that pattern have held true over the last 12 months?

A Yes.

Q Given what you do, I assume in the cases that you've done before, you've seen issues related to the type of issues we're looking at in this case, correct?

A Yes.

Q How much do you earn on average annually doing this type of legal work?

A It's approximately 80 to 90 percent of my salary.

Q Which is how much?

A 145.

Q We're looking at 120,000, 130,000 on legal work a year?

A Roughly.

Q How do you normally get your cases?

A By just an email or a phone call.

Q You're not listed on any expert referral services like the Expert Institute or anything like

that?

A Not that I know of. No.

Q Sure. And maybe they put you up there because they're trying to sell people that you don't even know about. As far as you're aware though, you've entered into no contract with, like, an expert referral service, correct?

A Oh, no.

Q Okay. Have you ever provided expert review services to Mr. King's firm, Franklin&Prokopik, before?

A Not that I recall. No.

Q Okay. Have you ever worked -- Mr. King has only been there for a few years, I believe. Have you ever worked with Mr. King before?

A No.

Q Have you ever worked on any cases involving McKesson before? And the reason I ask is they're one of the defendants in this case.

A Involving who? I'm sorry?

Q McKesson, the medical device company?

A Oh. No, sir.

Q Okay. And your CV does, and I know I still have it up, it indicates that you are a professor, correct?

A Well, technically an associate professor.

Q Okay. It also indicates you do some publishing work, correct?

A Yes.

Q Can you give me a current breakdown of percentage, if that's easy, as work between your professor work, your legal work, your publishing work, anything else I may be missing?

A Well, my -- my clinical obligations are -- are far and away the largest, I would guess, let's say, 80 -- 80 percent would be devoted to that, and then the rest would be a combination of training and scholarship/writing.

Q When you say your clinical work, that includes your legal reviews, correct?

A Yes.

Q And I know we talked about the money before, but is it fair to say that 80 to -- 80 to 90 percent of your clinical work is for legal reviews as well?

A Yes.

Q Okay. Have you ever been qualified as an expert witness in court?

A Yes.

Q In neuropsychology?

A Yes.

Q Okay. Have you ever been excluded from

providing expert testimony in court?

A No.

Q Have you ever been limited from providing expert testimony in court?

A I know that's been discussed before, but I don't recall the -- the sort of outcome.

Q Sure. And I guess I just want your understanding. There's a lot of times where a legal decision comes down involving an expert, and they don't even inform the expert. The attorney just works through it on their side of thing. So I'm just looking for your understanding as to what you may know about your testimony being limited in the past for any court.

A I can recall discussions, but I really don't recall content or -- or the -- the consequence or the outcome of it.

Q Have you ever been told that you are not allowed to testify that a plaintiff is not credible?

A I don't think so, though that -- that's something related to that is likely to be what has been discussed.

Q Have you ever been told that you are not allowed to testify to one or any of the tests that you provide because they do not meet the standard required for court admissibility?

A No.
Q What is malingering?
A Malingering is the intentional production or false -- or -- or grossly exaggerated symptoms motivated by an external incentive to do so.
Q Okay. It's pretending to be ill, correct?
A It is, yes.
Q Okay. And it would include feigning symptoms, correct?
A Yeah. Feigning is a similar term. It's a little bit broader. Not quite as specific a definition. But yeah, similar.
Q At base, it's not telling the truth, correct?
A Well, yeah. I don't know if I would -- I would say that. I would focus on just whether or not it's an accurate portrayal of the -- of the symptoms.
Q Well, you did say the word "intentional" in your definition, correct?
A The definition does include that.
Q Right. So if someone is intentionally exaggerating their symptoms or stating symptoms that don't exist, that would be not telling the truth, correct?
A And that -- that would be malingering. Yes.
Q Okay. So malingering, put simply, is lying,

correct?

A Well, it's a very specific type of behavior. It's -- it's a misrepresenting your symptoms for a very particular reason.

Q Sure. But it's an intentional misrepresentation, correct?

A Yes. If it -- if it is actually malingering. Yes.

Q Right. And I know that there needs to be some sort of outside motivation, secondary motivation for gain in terms of that, but to start with, before you even get to the motivation, it is an intentional misrepresentation, correct?

A That's right.

Q Okay. An intentional misrepresentation is lying, correct?

A I suppose in lay terms, I -- I -- as a clinician, I wouldn't use that term.

Q Okay. Have you ever looked at the dictionary definitions of malingering?

A I'm sure I have, but I don't recall what they might say.

Q All right. Can you see what has been pre-marked as Exhibit 2?

A Yes.

Q All right. This is from the Oxford Advanced Learner's Dictionary. "malinger verb." It says, "to pretend to be ill, especially in order to avoid work." Did I read that correctly?

A I'm not really able to see it.

Q Sure. I think there's a way to make your screen full screen, but I can zoom in for you.

A That helped. You might have to page up or down because I don't see what you just said.

Q The word malinger verb is, "To pretend to be ill, especially in order to avoid work." Did I read that correct -- did I read that correctly?

A Yes, you did.

Q Do you accept that definition of malinger?

A I don't think it's great. It's -- it's -- I don't think it's false. It's just overly specific.

Q Okay. And overly specific because it -- it specifically says avoid work is the motivation, correct?

A Correct.

Q And there can be other motivations for a malingerer, correct?

A Correct.

Q All right. If I go down a bit, this is from Merriam-Webster. Again, we have malinger, and this one says, the definition is, "to pretend or exaggerate

incapacity or illness," and then in parentheses it says, "(as to avoid duty or work)" Did I read that correctly?

A Yes.

Q Do you think that is a better definition?

A Not really. But it's -- it's, like I said, I don't think it's false. It's -- it just don't -- it doesn't capture the -- the full definition in my opinion.

Q Okay. There's a little, did you know -- did you know section here in the Merriam-Webster dictionary that I -- I just pulled up. And it says, "The verb," I'm reading like the third or fourth sentence in, "The verb malinger comes from the French word malingre, meaning "sickly," and one who malingers feigns illness." Did I read that correctly?

A Yes.

Q Okay. You would agree that a malingerer is feigning illness, correct?

MR. KING: We object to the form. I think it's been asked and answered, and it's now becoming argumentative subject to that.

THE WITNESS: So I -- I would say -- can you restate the question? I'm sorry.

BY MR. LADUCA:

Q Sure. Would you agree that a malingerer is

feigning illness?

A Yes. Malingering is a type of feigning.

Q Okay. The last line there says, "Today, malinger is used in just about any context in which someone fakes sickness or injury to get out of an undesirable task." Did I read that correctly?

A Yes, you did.

Q Do you agree that someone that is malingering is faking?

A Yes.

Q Okay. There are four types of malingering, correct?

A I -- I tend to think of it that way, but I don't know that everybody does.

Q All right. Well, what are the four types that you're -- that you tend to think of?

A Oh gosh. Invention, transference -- I could probably just describe them. So one would be just outright fabricating symptoms without any genuine symptoms at all. Another would be exaggerating genuine symptoms. Another would be saying that you had symptoms -- well, sorry. Take that back.

One other version would be to say that you still have symptoms when you don't actually, even though you did have them. And then I'm missing one. Yeah.

And there's exaggeration, outright fabrication, fabrication. Those are -- those are the ones that are occurring to me. I can't think of the other one right now.

Q Did you describe transference?

A Yes. I believe so.

Q And did you describe perseveration?

A Yes.

Q Okay. So invention, perseveration, exaggeration, transference, those are the four, correct?

A Okay. Yeah.

Q You'd agree with me?

A Yes.

Q You'd also agree that there are gradations of certainty when it comes to malingering, correct?

A Yes.

Q And what are those?

A Well, they're up to the clinical judgment of the person, what you want to call them, but I mean, you can be very sure, you can be pretty sure, you can be not very sure, somewhere in between.

Q Well, it's actually -- it's definite malingering, probable malingering, and it used to be possible malingering, correct? But they've -- they've gone away with that, correct?

A That -- yeah. According to the SLICC criteria. Yeah. That -- that's -- those are the terms they would've used. Yeah.

Q Okay. Let's look back at your CV for a second. Can you see that again?

A Yes.

Q All right. It's clear to me, at least from your CV. So I want to ask you, do you agree you focus your career on the concept of malingering or feigning and the law?

A Yes. I've spent quite a bit of time on that.

Q All right. If we look at page 5 of your CV, starting with your "Dissertation topic:" that was, "Cognitive feigning detection in neuropsychological assessment: Validation of the TOCA." Correct?

A Yes.

Q So right off the bat, in school you're writing your most important paper on cognitive feigning, correct?

A Yes.

Q Which is in the same subset as malingering, correct?

A Yes.

Q You've edited one textbook, correct?

A Yes.

Q It's called "Clinical Assessment of Malingering and Deception," correct?

A That's correct.

Q And if we look at your publications -- let's start with the seventh one, that publication's called "Malingered Traumatic Brain Injury," correct?

A Yes.

Q And that was printed in Clinical Assessment of Malingering and Deception, correct?

A Correct.

Q Which is the textbook you edited, correct?

A Yes.

Q In the case we're here talking about today, Plaintiff has alleged a traumatic brain injury, correct?

A Yes.

Q The eighth publication on this list is called "Neuropsychological Models of Feigned Cognitive Deficits," correct?

A Yes.

Q And that was printed in the same textbook; Clinical Assessment of Malingering and Deception, correct?

A That's right.

Q The ninth publication on your list is, "Response Styles and Malingering," correct?

A Yes.

Q The 11th publication you list in your CV is called "iatrogenic symptoms and malingering following concussion," correct?

A Yeah. PCS Iatrogenic Symptoms and Malingering Following Concussions.

Q And that was printed in a publication called "Evaluation of Malingering and Deception," Correct?

A That was printed in Psychological Injury and Law, I believe.

Q Okay. The plaintiff in our case is claiming a concussion, correct?

A Yes.

Q The 13th publication you list in your CV is called "A critical analysis of the MND criteria for feigned cognitive impairment," correct?

A Yes.

Q MND stands for malingered -- wow. Malingered neurocognitive dysfunction, correct?

A Yes.

Q The 15th publication here is called "Feigning Mental Disorders with Concomitant Cognitive Deficits: The Purported Disability of Mr. E. Z." Correct?

A Yes.

Q The 17th publication you list in your CV is

called "Malingered Traumatic Brain Injury," correct?

A That's correct.

Q And that, again, was printed in "Clinical Assessment of Malingering and Deception," correct?

A Yeah. An earlier edition.

Q Right. The 18th publication you list in your CV was a, "Book review of K. B. Boone's Assessment of Feigned Cognitive Impairment: A Neuropsychological Perspective," correct?

A Yes.

Q The 19th publication you list in your CV is called "Detection of neurocognitive feigning: Development of a multi-strategy assessment," correct?

A Yes.

Q 22nd publication you list in your CV is called "Evaluation of Malingering and Deception," correct?

A Correct.

Q And we've talked a lot about malingering in that list, but you've really tried to bring that focus on malingering into the law, correct?

A I'm not sure I understand the question.

Q Well, you teach at the Institute of Law, Psychiatry and Public Policy, correct?

A Yes.

Q And if we go through your list again, the

first publication that you list was printed in the Handbook of Psychological Injury and Law, correct?

A That's correct -- that's correct.

Q The second publication listed in your CV was printed in the Oxford Handbook of Psychology and Law, correct?

A Correct.

Q The third publication listed in your CV is called "Competence to stand trial," correct?

A Yes.

Q And it was published in "Casebook of mental capacity in US legislation: Assessment and legal commentary," correct?

A Correct.

Q The 13th publication you list in your CV was published in a publication called "Psychological Injury and Law," correct?

A Yes.

Q As was the 14th publication, correct?

A Correct.

Q The 16th publication you list in your CV is called "SLAM on the Stand: How the Sports-Related Concussion Literature Can Inform the Expert Witness," correct?

A Correct.

Q And Doctor, you list 24 publications in your CV, correct?

A Yes.

Q And almost every single one of them has to do with malingering and the law, correct?

A The majority do, for sure.

Q Okay. And we can go through your presentations if we need to, but you'd agree with me that almost every single one of your presentations in the same vein has to do with malingering and the law, correct?

A I would say most do. Yeah.

Q Okay. So your entire career has been focused on proving that individuals claiming injuries in connection with legal matters are malingering, correct?

A No.

Q All right. Well, you do have a fairly high stake in having malingering being accepted as legitimate by courts, correct?

A Well, I -- I've never thought of it that way. I'm -- I'm interested in the detection strategies being valid and reliable so that we don't misidentify people as malingering when they're not.

Q And yet, 70 percent of the time in civil cases, you work on the side that's trying to say that

the injuries are not as severe as they actually are claimed to be, correct?

A Yes. And I -- I don't see that related. But yes.

Q Okay. What is the DSM-5?

A It's the Diagnostics and Statistical Manual, Fifth Edition.

Q Okay. Malingering is not actually a medical diagnosis at all, is it?

A That's right.

Q How is it described in the DSM-5?

A It's a condition for -- of further interest.

Q Right. And definitionally in the DSM-5, I believe it's the intentional production of false or grossly exaggerated physical or psychological symptoms, correct?

A Motivated by an external incentive. Yes.

Q Okay. But again, intentionally false or exaggerated, in the DSM-5, correct?

A That's right.

Q There is no way for you to scientifically prove someone's intent, correct?

A Not yet. No.

Q Okay. And you talked about it being a condition that warrants clinical consideration. It

receives what's a -- what's called a V code, correct?

A That's right.

Q And what is a V code?

A It is a categorization or a classification of behavior that is considered important, but isn't -- it isn't a diagnostic entity.

Q Right. Any attempt to equate it to a diagnosis would be, in some of your writings I've seen, that would be an egregious error, correct?

A I don't know that I would say it's egregious. It's -- we're stuck in a position where we're using diagnostic methods to try to classify that type of behavior. And at this point, it's probably the best way of doing it, but it's -- it's not error free, for sure.

Q Have you ever -- you wrote a publication called "Evaluation of Malingering and Related Response Styles," correct?

A Yes.

Q Do you remember writing in that article, Any attempt to equate DSM-5-TR with a diagnosis of malingering is an egregious error?

A I don't remember writing that, but I don't disagree with it.

Q Okay. Malingering is not a mental illness, correct?

A Malingering is not a mental illness. No.
Q Right. And because to call someone a malinger is simply to say that they're lying, correct?
A No, I -- I --
MR. KING: Object to the form. Asked and answered.
THE WITNESS: No. I think there -- there's more specificity to it than that.
BY MR. LADUCA:
Q It is an evaluation of that person's credibility, correct?
A Yeah. And -- and more pertinent to me, it is the evaluation of the data as -- as valid and -- and reliable.
Q Sure. But you have multiple neuropsychologists that look at the same set of data and come out two different ways, correct?
A Occasionally. I guess it depends.
Q Right. So if someone can look at the same sets of data and come out two different ways, and we're trying to determine whether someone is intentionally misrepresenting something, that is a determination on that person's credibility, correct?
MR. KING: Object to the form.
THE WITNESS: When it -- yeah. When it

comes to the determination of intentional production, there's only a couple of ways to do that psychometrically. Usually it comes down to the clinical judgment of the examiner.

BY MR. LADUCA:

Q Okay. You do accept that the jury gets to decide who's telling the truth in this case, correct?

A I do.

Q And you agree that there is no science or medicine to date that can prove to a reasonable degree of professional or medical certainty that a person is malingering, correct?

A I don't know that I agree with that. I think to a reasonable degree, you can determine that. I mean, there's examples that you can come up with where the incentive is -- is obvious, is -- is overwhelming, and they're performing in such a way that it can't be explained any other way except feigning.

And when you put it all together, more reasonable than not to conclude that they are feigning. And then there are -- you know, there's situations too when you -- you just see the person doing the thing that they have claimed that they can't do, those sorts of things.

Q Sure. All right. Let's get to your report.

You have it in front of you, correct?

A Yes, sir.

Q It may be easier for you just to go through on your report, but for the record, I'll say that I've pulled up Exhibit 3. And this is the report that you wrote in connection, once I actually pull it up, with your evaluation of Ms. Dillon, correct?

A Can you enlarge it just a little bit --

Q Yeah.

A -- please?

THE REPORTER: And Attorney LaDuca, do you have it uploaded to the platform under My Exhibits?

MR. LADUCA: I can put it on there. I've used that before and it hasn't worked.

THE WITNESS: I -- I can see it now if that --

MR. LADUCA: Yeah. Can you see it?

THE WITNESS: Yes.

BY MR. LADUCA:

Q Okay. Is what's been marked as Exhibit 3 the report that you wrote in connection with your evaluation of Ms. Dillon in this case?

A It appears to be. it's the first page of it, so I -- I'm willing to accept that it's the whole report. Yeah.

Q Fair. It's the report dated January 3rd, 2024, correct?

A Correct.

Q I know you said you've worked on probably between 100 and 200 cases in your career. How many of these types of reports have you written?

A These types meaning?

Q A neuropsychological evaluation in connection with a civil legal case.

A 70. 65 to 70.

Q In this report, on the first page, you summarized all of the medical records you had at the time of your evaluation and writing of this report, correct?

A That's right.

Q And you didn't leave anything out that you had at the time, correct?

A That's right.

Q Okay. Those are the records that at the time you relied upon in reaching your conclusions along with your evaluation and testing, correct?

A Correct.

Q You did not list Dr. Cintron's record in your sources of information. Is that because you didn't have them?

A I did not have that.
Q You understand that Dr. Cintron along with being an expert in this case, is actually plaintiff's treating neurologist, correct?
A Yes.
Q Okay. And at the time of writing your report, you had not seen any of the other defense doctor reports, correct?
A That's correct.
Q Sitting here today, have you reviewed any deposition transcripts?
A Yes.
Q Okay. Which ones?
A Ms. Dillon's, and I believe that's it.
Q Okay. Are you relying on any other expert's opinion? And it could be Plaintiff or Defendant's, to support your opinion in this case?
A No.
Q Okay. Have you talked to any other expert in this case about this case?
A No.
Q Do you know any other expert in this case?
A I mean, I -- I know Dr. Hebda professionally.
Q Do you know any of the treating medical providers involved in this case?

A And I -- I do know of Dr. Cintron.

Q Okay. But -- and those are both experts, and Cintron is a treater, but you look through the records that you had, do you know any of the actual treating medical providers?

A Oh, no.

Q Okay. Have you talked to any of your colleagues about this case?

A No.

Q Do you have all of the information you feel is necessary to render an opinion in this case?

A Yes.

Q Let's go to page 13. I want to go over a couple of your conclusions and we'll jump around a little bit. There is a section there called "SUMMARY AND IMPRESSIONS," correct?

A Yes.

Q And this is where you put your conclusions after your testing, review of the record, your evaluation, correct?

A That's right.

Q The last line of the first paragraph reads, "In short, if Ms. Dillon sustained a concussion, it was very mild." Did I read that correctly?

A Yes.

Q You are not a neurologist, as we've established, correct?

A That's correct.

Q You don't diagnose concussions, correct?

A We do pretty routinely, actually.

Q Well, doesn't a concussion diagnosis have to come from a medical doctor?

A I -- I don't know that it does or doesn't.

Q Okay. Because I agree with you that you can talk about the effects of a concussion, but the actual diagnosis itself, my understanding, has to come from a neurologist or some sort of medical doctor. So is that contrary to your understanding?

A We get referrals from physicians every day to do that very thing because they're having trouble in some way. So we -- we're asked to do that routinely.

Q Okay. In your next line, you state that, "A return to baseline cognitive functioning occurs within 2-3 months in the majority of cases following concussion, and within 2-3 weeks for those experiencing a mild concussion, as appears to be the case for Ms. Dillon." Did I read that correctly?

A Yes.

Q You do say "a majority of cases," in that statement, correct?

A Yes.

Q There are cases where symptoms persist for months after a concussion, correct?

A Yeah. It's a very small group. But yes.

Q Okay. And in some patients, those symptoms actually become chronic, correct?

A Yeah. That's a -- that that's a -- an area of intense research right now. I think the -- the significant thing to take from that -- that issue is that, well, one, I would say, yes, there -- there is a portion that continue to have symptoms for a long time. It's the nature of those symptoms and the -- the proximal causes of those symptoms that I think are very significant.

Q Okay. Who's Muriel Lezak?

A She was a professor of neuropsychology, one of the founding American fathers, really, or mothers I should say.

Q And Lezak has authored a study that found that symptoms from a concussion can become chronic and as high as 15 to 20 percent of patients, correct?

A I don't recall that study, but I -- I would say that she as -- as prolific and amazing as she was, concussion wasn't her area. And there -- there are several experts in the field who have done a lot more

work in concussion than she ever -- ever could.

Q Okay. So do you disagree with the 15 to 20 percent number being -- go ahead.

A I'm sorry. I -- I would have to see the study and say -- to -- to see what she was defining as concussion, how she defined it, what the symptoms involved were, and, you know, the other -- other considerations.

Q All right. Well, no matter what the percentage may be, if we accept that a subset of the patient population does become chronic -- have chronic symptoms stemming from a concussion, there is a possibility that Ms. Dillon could just be part of that subset, correct?

MR. KING: Object to the form.

THE WITNESS: Yeah. I'd say it's a very low probability and that if she continues to have symptoms of -- of some kind, they're not due to brain damage.

BY MR. LADUCA:

Q Okay. You talk about in that line Ms. Dillon's baseline, correct?

A Yes.

Q What is a baseline?

A Well, in -- in this context, it's their usual

level of functioning.

Q Okay. How do you determine a baseline for an examinee?

A Yeah. Well, we look at -- at metrics that tend to be resistant to change or compromise over time and use that. We also look at academic history, occupational history, things like that.

Q What was Ms. Dillon's baseline prior to this incident?

A I think I estimated it to be high average.

Q Okay. You go on to say in that paragraph, I think it's a couple sentences later, that, "Ms. Dillon presented with various pain complaints for much of her recovery, which could be a reasonable explanation for her cognitive complaints." Did I read that correctly?

A Yes.

Q What you mean by that is, as a general concept, pain can cause cognitive difficulties, correct?

A As a general concept. That is correct.

Q Okay. And according to your own language there, in Ms. Dillon's case, you agree that it is possible that her incident-related pain is associated with cognitive difficulties, correct?

A Yes, that's -- that's correct on the surface. The -- the devil's in the details there, though, because

it's difficult to establish just how severe her pain is and how -- and therefore establish how significantly it might be impacting cognition.

Q Right. And the -- and the reason you find it difficult is you just don't believe Ms. Dillon, correct?

A No, no, I -- that's not that at all. I -- I just -- I -- there's compelling evidence that her scores are unlikely to be accurate when it comes to her level of pain and other -- other symptoms that she's reporting.

Q All right. In the same paragraph, I believe -- yeah. Maybe -- right next line, you state that, "objective testing today reveals that she," meaning Ms. Dillon, "is very likely overstating her pain and she sees her life as unrealistically terrible." That's what you wrote, correct?

A Correct.

Q That's a credibility determination, correct?

MR. KING: Object to the form.

THE WITNESS: It's -- it relates to it. Yes.

BY MR. LADUCA:

Q Okay. But you're saying that she's overstating her pain, correct?

A Yes.

THE WITNESS: Just one moment, please.

MR. LADUCA: Yep.

THE WITNESS: I was getting some glare out of my window. Sorry about that.

MR. LADUCA: No worries.

BY MR. LADUCA:

Q And by saying you're -- she is overstating her pain, you're saying she's lying, correct?

A No. That's not what I would say.

Q Okay. When you tested Ms. Dillon, what exactly were you looking for?

A I was doing a comprehensive neuropsychological evaluation, which means I'm -- I'm looking for objective evidence of neurocognitive dysfunction as well as personality dysfunction, psychological distress. I'm also looking at the degree to which the data that I have is valid and reliable.

Q Okay.

A And in other words, is it usable? Is it useful?

Q All right. To make it simpler, were you looking for a mental disorder?

A Yes.

Q And you were looking for cognitive symptoms, whatever they may be, correct?

A That's right.

Q Were there specific cognitive symptoms that you were testing for in your evaluation of Ms. Dillon?

A Yes. Many.

Q Which ones?

A Anything involving perception, speech, language, memory, attention, concentration, processing speed, reasoning, judgment. So those would be the kind of the big neurocognitive domains. But then also the whole, you know, wide gamut of -- of psychopathology, like depression, anxiety, bipolar disorder, and personality disorders.

Q I mean, it sounds like, to be frank with you, Doctor, you just gave me everything a neuropsychologist could look for. You agree that it's essential that a practitioner know what they were -- they are looking for in a specific case when performing an evaluation, correct?

A There's different opinions about that. Some people believe a blind exam is better because you don't go any -- with any biases. I tend to believe that you should know something about what you're -- you're getting into because it'll guide the type of questions that you ask.

In concussion, there's such a wide variety, or

-- or at least in -- in post-concussive syndrome, there's such a wide variety of things that you might see that it makes sense to assess quite a number of things.

Q Well, do you remember writing the exact words that is parroted to you that a -- that a practitioner should know what they are looking for in a specific case when performing an evaluation?

A I don't remember writing that, but I -- I do agree with that.

Q Okay. So what were you looking for rather than the wide net that you casted with Ms. Dillon? Were there specific things you were looking for when you examined her?

A I think the -- those things that I listed already, it's -- it's very difficult to know what -- you know, going -- going into an examination of someone who has reported a concussion and reports post-concussive syndrome, it's very -- very difficult to be very precise with your exam because there's so many possible things that could be manifesting as a result of those issues.

Q Did Ms. Dillon report any rare symptoms to you during her evaluation?

A Yes.

Q What?

A Well, one -- one thing that comes to mind

right now is her -- her rating of how poorly she was doing. So it's rare for someone to report, for example, that they're functioning at about 5 percent of their baseline. So by itself, that's rare to have someone report that. But then to have that person also be someone who's working full time, that's extremely rare. And then her -- her profile on the MMPI-2 revealed that she was reporting some rare things as well.

Q What is the definition of a rare symptom, doctor?

A Well, on the -- on the MMPI, it's defined by the -- the rate or the base rate of that complaint being reported by the population, the general population.

Q Okay. Did Ms. Dillon report any improbable symptoms to you during her evaluation?

A Only -- yeah. Yes. And to the extent that they were tied to certain things. So she -- she reported a great deal of gastrointestinal distress many months and years after a concussion. That's not really a known consequence of that. So that's improbable that it would be connected to that.

Q Ms. Dillon didn't tell you that she thought her gastro was connected to the concussion, did she?

A I don't remember.

Q Okay. So it would be unfair to say that she

reported an improbable symptom in the form of gastrointestinal problems and then tie it to her saying it was related to the concussion when she didn't say that, correct?

A I think, I -- I think the context matters. I mean, this is -- it's -- it's -- she had -- she tied a great deal to the -- to the concussion. I just don't remember if that was one of them.

Q Okay. But fair to say that when a patient reports symptoms are related to X condition, that they actually have to say that in order for it to be an improbable symptom, correct?

A Or it would have to be true in some way. That you -- them telling you that would be one way. Yeah.

Q Right. But if she sat there and said, I have gastrointestinal problems that I've had for my entire life, has nothing to do with the incident or the concussion. It would be unfair to classify that as an improbable symptom in connection with the concussion that you're evaluating her for, correct?

A It would -- I guess it would be unfair to say that she believed that. It wouldn't be unfair to say that it's still improbable for that to be associated with concussion.

Q Right. But you attributing her to saying that

it was related to the concussion would be unfair, correct?

A Yeah. Yeah. I wouldn't be able to say she said it if she didn't say so.

Q Well, you also wouldn't be able to use it as a classification of an improbable system -- symptom in your evaluation because then you would just be saying, I'm going to say that the gastrointestinal is related to the concussion, even though she's explicitly saying it's not, correct?

MR. KING: Object to the form.

THE WITNESS: It -- it's still what was -- what -- what -- I'm getting that information from an empirical scale that she -- she reported this unusual constellation of symptoms in the context of concussion. So I don't recall if she did say it was tied to the concussion or not. She may have, but either way, the scale elevation is the thing that's significant to me.

BY MR. LADUCA:

Q Okay. You brought up constellation, another word for combination. What unusual symptom combinations did she report to you?

A Unusual? I don't recall at the moment.

Q Okay. And she actually did report that her symptoms were at varying levels of intensity and

severity, correct?

A Yeah. That they -- that they varied. Yes.

Q Okay. And she even told you that some of her symptoms have gotten better over time, correct?

A She did.

Q Okay. Did she report symptoms selectively in your opinion?

A I don't believe so.

Q Okay. Other than having a prolonged recovery, the symptoms that she reported are in line with those are -- that are expected by a patient with a concussion and orthopedic injuries, correct?

A I would say most of them are. Then, again, with the MMPI-2 being very instructive with regard to these unusual combination of symptoms, that wouldn't be expected in that context.

Q Right. But the symptoms themselves, and I know you have a problem with how long they've lasted, the symptoms that she reported themselves, and I think you said most of them, they are mostly concussion related-symptoms, correct?

A Yeah, there's -- it's -- that's the thing with concussion-related symptoms. There's just so many. It's -- it lacks specificity as a -- as a diagnostic entity, unfortunately.

Q What tests do you believe objectively tests for malingering?

A Well, it would -- well, there's many. All of them are incomplete in the sense that they can't assess for the motivation that underlies the behavior. But there are a number that are well-validated identifying overstatement, exaggeration, distortion, for whatever reason, and then there are a couple that actually do identify intent that they did it deliberately.

Q You keep bringing up the MMPI. The MMPI, maybe you don't know this, do you have any understanding whether the MMPI has been repeatedly disallowed in courtrooms?

A I don't know of that.

Q Okay. The MMPI-2-RF is actually a test for feigned mental disorders, correct?

A In part.

Q A feigned mental disorder is different than feigned cognitive impairment, correct?

A They can be related, but they're different. And the MMPI-2-RF does have feigned cognitive scales on it.

Q Okay. Well, in that article, we talked about a couple times, evaluation of malingering and related response styles. You stated that feigned cognitive

impairment differs fundamentally from feigned mental disorders in terms of detection strategies, correct?

A No. That's -- that's absolutely true.

Q Okay. And in that article, you talk about the MMPI-2-RF as being a test to detect feigned mental disorders, correct?

A It is that, but it is not only that.

Q Okay. She's not claiming a feigned mental -- or sorry. She's not claiming a mental disorder, correct?

A Ms. Dillon --

Q Yes.

A -- is not -- well, I -- I -- I'm not sure what she's claiming, actually. I -- I know Dr. Hebda feel -- Dr. Hebda feels like that she had a mental disorder.

Q What mental disorder?

A An adjustment disorder.

Q Okay. Ms. Dillon herself is only claiming cognitive impairment, correct?

A I don't know that I was aware of that.

Q Did you know that when you went into your testing of Ms. Dillon?

A No. I just knew that she was reporting post-concussive symptoms.

Q Okay. What independent strategies did you use

to validate feigned cognitive impairment versus feigned mental disorder?

A Well, I used the tests that we call PVTs for the cognitive side and then SVTs for the psychiatric side, with the MMPI-2 really being the only one that does both.

Q You'd agree with me generally that forensic evaluations don't represent the optimal conditions for the assessment of cognitive functioning, correct?

A Yes. I don't know that I've experienced the -- the optimal one yet.

Q Well, again, a lot of this stuff, I'm just repeating what you've written before. So you'd agree that forensic evaluations don't represent the optimal condition for the assessment of cognitive functioning, correct?

A I would agree with that.

Q Let's go to your discussion since we're on the topic of the MMPI-2-RF results, which are on page 12 of your report right there in the middle. Let me know when you're there.

A Oh, yes, I'm there. Thank you.

Q All right. Let's read the very first line because I actually think that may be one of the most important lines in your entire report. You wrote, and I

quote, "On the MMPI-2-RF, Ms. Dillon generated a larger than average number of infrequent responses, which may occur in individuals with genuine psychological difficulties who report credible symptoms." Those are the words you wrote, correct?

A That's right.

Q That Ms. Dillon's responses on the MMPI may occur in individuals with genuine psychological difficulties who report credible symptoms, correct?

A That's correct.

Q And despite that, you decided that Ms. Dillon's responses, which may be indicative, as you write, of genuine psychological difficulties with credible symptoms, was not credible, correct?

A That's right.

Q Okay. And that's because -- and that's your opinion because as you state multiple times in this paragraph, Ms. Dillon has a very unusual combination of responses, correct?

A Well, it's for a number of reasons, but that's one of them.

Q Okay. And that's your interpretation of the MMPI data, correct?

A Right. Yeah. That first sentence is based on one scale, and then the rest -- the other sentences are

separate scales. So you have to look at it cumulatively to see what the predominant finding would be with regard to her responses.

Q Your overall interpretation of Ms. Dillon's MMPI-2-RF results indicate to you that Ms. Dillon is malingering, correct?

A It indicates that there's an elevated probability of that.

Q Okay. It indicates to you that she's lying, correct?

A That's not what I would say. No.

Q Well, we can go through it again and Ms -- Mr. King will probably say asked and answered, but didn't we already establish that malingering is an intentional misrepresentation?

MR. KING: I will object. Asked and answered.

THE WITNESS: Yeah. Yeah. We have. I don't think we -- I -- I just don't -- I don't use that kind of terminology. I don't find it helpful in my clinical examination.

BY MR. LADUCA:

Q Well, right. But for the jury, I think it'd be helpful to understand, without you mincing words, what you're saying. You are calling her a liar,

correct?

MR. KING: Object to the form. Asked and answered.

THE WITNESS: I'm -- I'm pointing out evidence that shows that what she is reporting is likely inaccurate.

MR. LADUCA: All right. We'll see how the jury takes that. But let's look at --

MR. KING: Object to the form. Object to the form.

BY MR. LADUCA:

Q Let's go a little bit further on in that paragraph. You wrote -- and I don't know why this is here. She -- you wrote, "She likely holds grudges, has temper tantrums, and is argumentative and abusive." You wrote that, correct?

A Right.

Q Why in the world is that in this report?

A Well, it's something that speaks to personality traits and the way she manages stress, and both -- both of those are significant considerations.

Q All right. Do you have any evidence, real world evidence, not the personality test, that Ms. Dillon has ever thrown a temper tantrum?

A I -- I don't. That's why it says likely in

there, and that's why it's under the section of the MMPI-2 and not anywhere else.

Q Okay. Do you have any evidence that Ms. Dillon has ever been abusive?

A I don't believe so.

Q Okay. You do recognize that the MMPI results that you list indicate considerations of things other than malingering, correct?

A I'm sorry. Can you restate?

Q Sure. The MMPI results that you list indicate considerations of things other than malingering, correct?

A That is correct.

Q And you've already agreed that Ms. Dillon's results may reveal genuine psychological difficulties, correct?

A Yes.

Q Okay. Some other indications that you list here revealed by the MMPI results are depression, correct?

A That's correct.

Q And anxiety-related disorders including PTSD, correct?

A Correct.

Q Do you have an understanding sitting here

today whether Ms. Dillon has been diagnosed with PTSD?

A My understanding is that she has not.

Q Okay. I'll represent to you that she is seeing a therapist and has been, but you haven't seen that, so it would be unfair to really talk to you about it. But I'll also represent to you that last week, Dr. Trachman, whose report you have now seen, another of the defense experts in this case, testified that it's her opinion that Ms. Dillon has depression and anxiety, which was either caused by the incident or was exacerbated by the incident. Does that opinion surprise you?

MR. KING: Object to the form.

THE WITNESS: Does anything about that opinion surprise me? No.

BY MR. LADUCA:

Q Do you agree that Ms. Dillon suffers from anxiety and depression as a result of the subject collision?

A I think she -- I think she did. I think it's harder to say that she still does.

Q Okay. But despite the other indications and you even agreeing that depression and anxiety were caused by the incident, you're still going with malingering or symptom exaggeration, correct?

A No. That's just part of my differential. I -- I don't think I ever -- well, I know that I don't ever come out and say she's malingering because I don't believe that I can say that. I don't have evidence to support that. I -- I have evidence to support an elevated probability that she is. But there are -- there's other moving parts as well.

Q You believe she's exaggerating her symptoms, correct?

A I do believe that. Yes.

Q Okay. In the course of your career, how many times have you provided the opinion that a plaintiff in a civil litigation is exaggerating or feigning their symptoms?

A I don't think I know that number.

Q It's dozens, correct?

A It would -- given the number of times I've done this type of evaluation and the base rate of malingering, I would guess it's probably -- yeah, probably dozens.

Q You yourself have written in warning to other psychologists that, and I quote, It has been our forensics experience that a small amount of feigning evidence is given greater weight than a greater amount of any evidence for genuine responding. Do you remember

writing that?

A Unfortunately, no.

Q Okay. Do you agree with that?

A I think I'd need to know more about the -- the paragraphs before and after or what -- what context it's in.

Q All right. Well, I'll just ask you as a general concept. Do you agree that in your forensic experience, a small amount of feigning evidence is given greater weight than a greater amount of evidence for genuine responding?

A Depending on the nature of the evidence, yes. If it's compelling, well validated, reliable data, it doesn't have to be a lot to be more compelling than evidence of genuine responding.

Q What's --

A Go ahead.

Q Go ahead. What's the balance here? How much evidence did you have that she's feigning symptoms?

A I had -- I -- I don't know how to quantify it, but the quality is -- is high.

Q Okay. How much weight -- how much evidence did you have that she was genuinely responding?

A I have -- I have evidence of that too.

Q How close was the balance?

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

Q Okay. But you've decided that the evidence that you have that she's feigning or exaggerating her symptoms is greater than the amount of evidence that you have that she's genuinely responding, correct?

A Well, the -- the -- if there's presence of feigning any evidence at all, that would be remarkable, clinically or forensically. So that -- that even a little bit of evidence would be unusual and have to be pursued because the -- the presumption is that the person is genuine.

Q I think you've answered the question you kind of skirted around before. So it is your opinion that a small evidence -- small amount of evidence of feigning means more than a large amount of evidence of genuine responding, correct?

A If it's -- if it's good evidence, if it's reliable and valid.

Q Okay. According to the DSM, and I know what your response is going to be to this, for malingering to even be considered, there has to be a combination of factors, correct?

A Well, if you -- you might be talking about the index of suspicion, but unfortunately that does not work at all. And there's been a couple people who looked at

that, and it's a very, very problematic index.

Q Maybe that's where you -- you disagree with the DSM, correct?

A Oh, I disagree with the utility of the index of suspicion.

Q Okay. The DSM is the most widely accepted book when it comes to diagnosing mental health issues, correct?

A Yeah, absolutely.

Q But you don't accept that book when it comes to malingering, correct?

A Well, when it comes to malingering, the definition, I -- I wholly accept the definition. It's their attempt to provide a detection strategy has -- has failed when you actually subject it to research.

Q What are the factors that the DSM manual lays out for a consideration of malingering?

A A medical legal context, lack of cooperation, antisocial personality disorder, and gross mismatches between how they present and their -- their data.

Q All right. Let's start with the last one. There has to be a marked discrepancy between individuals claimed stress or disability and objective findings and observations, correct?

A Correct.

Q What is Ms. Dillon doing that she claims she can't do because of her incident-related injuries?

A What is she doing that she claims she can't?

Q Right.

A I don't -- I don't know that she is. I -- I think she reports a great deal of symptomatic burden and describes distress, but she is working full-time and seems to be attending to her activities of daily living.

She -- she did say she avoids being a passenger in a car because she finds herself kind of freaking out and take -- trying to take control and yelling at people, which might be an example of being abusive, I guess. That's what comes to mind now.

Q It could also be an example of someone that was in a motor vehicle collision that caused serious injury and a reaction to being in a car where she's fearing that is going to happen again, correct?

A Right.

MR. KING: Objection to the form.

BY MR. LADUCA:

Q Okay. Another of the factors to be considered is whether the patient lacks cooperation during the diagnostic evaluation, correct?

A Correct.

Q In your own report, we can look at it if you

need to, but on page 11, you agreed that Ms. Dillon put forth adequate effort during testing, correct?

A Yes. The test would suggest that, and I didn't see anything in her -- in the clinical encounter with her that would suggest she was not being cooperative with the process.

Q All right. And I know this is the one you probably disagree with most, so let me at least just ask. The DSM says another factor to be considered is the presence of antisocial personality disorder, correct?

A Correct.

Q But you disagree with that, correct?

A Well, that's -- that's certainly a major part of it. Yeah. It's a really good example of something that may be a common characteristics.

In other words, malingering may be common in antisocial personality disorder, but it is not a distinguishing characteristic of it either way. So it's -- it'd be a mistake to use -- use that as a sign of malingering.

Q Right. And just to be clear, Ms. Dillon has never been diagnosed with antisocial personality disorder, correct?

A I've seen nothing that would suggest that she

has been diagnosed with that.

Q Okay. Under the DSM criteria, Doctor, Ms. Dillon does not meet the criteria for malingering, correct?

A I think she -- again, I would -- I would pose it in terms of probabilistic outcome. So I -- I would say that the -- there's a higher probability that she does, but there is -- there's no lab test, no blood work that I can do to say I know that she is motivated to behave that way due to external incentives. Therefore, she would fall short of the definition in the DSM.

Q On the top of page 13, it is the second line down, there's a sentence that reads, "It is possible, but unlikely, that multiple objective medical conditions are causing this unusual combination of physical symptoms and the possibility of a somatic symptom disorder should be considered." Did I read that correctly?

A Yes.

Q Ms. Dillon does have multiple objective medical conditions that are stemming from this incident, correct?

A I'm not sure I can opine on that.

Q Okay. Well, she had a concussion stemming from the incident, correct?

A Oh, we froze. Are you there?
Q Yeah. Can you hear me?
A Yes.
Q She did have a concussion stemming from the incident, correct?
A I believe it's reasonable to assume that she did.
Q Okay. It's more likely than not she had a concussion, correct?
A I would say barely. But yes.
Q Okay. And I know you're not an orthopedic doctor, but you reviewed the records. She also had cervical and lumbar injuries, correct?
A I did see that.
Q And she had a cervical surgery, correct?
A I saw that as well. Yes.
Q Okay. So there are substantial objective medical conditions that Ms. Dillon has had since the incident, correct?
A Yes. According to the medical records. Yes.
Q Okay. And it's possible, as you write here, that those injuries caused the unusual combination of those physical symptoms that you saw, correct?
A It's possible, but unlikely. That one sentence by itself doesn't capture the whole evaluation

of that issue.

Q What is somatic symptom disorder?

A It's a -- it's a -- an anxiety disorder basically that -- that is characterized by a focus on the person's bodily integrity and how things are going physically in their mind. And that's what makes it a mental disorder because it's -- it's what they think and feel about how they're physically functioning.

Q You looked at some of Ms. Dillon's pre-exist -- pre-injury records, correct?

A Yes.

Q Nowhere in those records did you see any diagnosis of somatic symptom disorder before the incident, correct?

A Yeah. That's pretty typical even when people have it.

Q Okay. So to the extent she suffers from that condition, the collision would've been the trigger for that condition, correct?

A It could be. It's -- it's -- yeah. I guess there's an argument to be made that there's -- it's a dormant condition until some stressor comes along. I -- I would disagree with the notion that it causes it outright because that -- that's not really how somatic symptom disorder works. But somehow be woken up by it,

yes.

Q Okay. And you've been doing this still -- long enough to know -- you take the plaintiff as they come, so if that -- she did -- she had this condition and it was dormant, and I'll give you that hypothetical even though you haven't seen anything in the records to show that she had this disorder, the thing that triggered it or the only thing that you have seen is the collision, correct?

A Right. And -- and the only difficulty would be differentiating it from feigned symptoms.

Q Sure. You also say that Ms. Dillon is self-reliant, correct?

A I believe I did say that somewhere.

Q Yeah. It's in the same paragraph. You said she's self-reliant that -- "She's so self-reliant that she is reluctant to accept help from anyone," correct?

A That's correct.

Q Meaning she does her best to fend for herself, correct?

A Yeah. I think that's part of it. Yeah. And it -- it's also a tendency to deny that she needs help or might benefit from it.

Q You also state that it is not unusual for a medical patient to have strained relationships with

their employer, correct?

A That's correct.

Q Why is that?

A Well, I think it's epidemiologically true. One, you just do a survey and people will endorse that. And there's probably a number of reasons why that might be true, but I -- I -- I'm taking that as just sort of a base rate phenomenon.

Q Okay. And like the base -- the base population or the base rate, as you call it, Ms. Dillon also endorses strained relationships with her employer, correct?

A Yes.

Q In your conclusion section, and I'm going to have to find it, second paragraph, you point out that Ms. Dillon says that, "on some days she is still just 5% of her baseline," correct?

A I do recall saying -- I see it now. Yes.

Q She did say some days, correct?

A Yes.

Q She did not say every day, correct?

A That's correct.

Q Okay. And she explained to you that those were days she had a panic attack or a pain flare, correct?

A That's correct.

Q Okay. And she actually told you that on good days, she's now 70 to 75 percent of her baseline, correct?

A Yes.

Q But you left that part out in your conclusion section, correct?

A Yes. That's correct.

Q You decided that pointing out her explanation of her bad days was more important to your conclusions, correct?

A Well, it -- it illustrated -- it was more -- that's the abnormal part of her report that is significant when considering the entire picture. To -- to think that she's functioning at 70 to 75 percent is probably still significant when it comes to concussion because that would still be less than what you'd expect to be functioning at due to concussion.

But this, I think, illustrated the -- the large discrepancy between her own impression of how she's doing and the evidence of how she's doing.

Q Right. But for your basis of -- of there being a large discrepancy, you're pointing out what you just admitted is the exception rather than the rule, correct?

A Right. Right. And this is another good example of the fact that it exists at all is the significance.

Q Okay. Pain is a subjective symptom, correct?

A I'm sorry. Say again?

Q Pain is a subjective symptom, correct?

A Yes.

Q Which means that it is patient reported, correct?

A It is.

Q Every medical doctor that I've spoken with, deposed, cross-examined, defense, plaintiff, doesn't matter, 100 percent across the board have testified there is no objective way to test for pain. Do you agree that there is no objective way to test for a patient's pain?

A I would agree with that.

Q Okay. You also agree that a person's perception of their pain is their reality of pain, correct?

A Yes. And it quickly gets less dichotomous and easy to characterize when you get into pain perceptions and cognitions. But for the most part, it is. And it's fortunate that we have objective ways of measuring that part because we can't do it with pain like you just

said.

Q Sure. But if they're subjectively reporting it, that's how they feel, correct?

A Yes. And unless they're feigning.

Q Right. Unless they're making it up, correct?

A Correct.

Q Okay. You point out here that despite Ms. Dillon's complaints, she still works full-time, drives, and attends to her activities of daily living, correct?

A Yes.

Q Aren't most malingerers trying to get out of things like that?

A Yes.

Q Okay. But she's still doing them, correct?

A Yes.

Q Okay. If Ms. Dillon wasn't working, you'd say that she should be, correct?

A Yes.

Q Okay. Ms. Dillon actually does not drive anymore, correct?

A I don't recall that.

Q All right. If you look at page 9 of your report.

A Yes.

Q If you look at the last paragraph, third line

down, you wrote, "She said she does not drive at all now after having driven for a while after the motor vehicle collision." Did I read that correctly?

A I -- I'm -- I'm sure you did, but I don't -- I'm still looking for it.

Q Well, I want you to see it. So the last paragraph down on page 9, three lines down, three words over, it starts with "she," and it says, "She said she does not drive at all now after having driven for a while after the MVC." Did I read that correctly?

A I see, yes. Yeah. I see the next sentence too. Okay.

Q But in your conclusion section, you said she still drives, correct?

A Yes. I did.

Q Why the discrepancy?

A That is an oversight on my part.

Q Okay. She also told you that she takes care of her daily activities, but she does so in pain, correct?

A I believe that's correct, though I do believe she does attend to them individual -- independently.

Q Sure. But in your conclusion section, you just say, "she attends to them without any qualification that she does so in pain," correct?

A That's correct.
Q You talk about, if we go back to that paragraph that we were talking about on page 13, the end there, that you put Ms. Dillon through five plus hours of testing, correct?
A Yes.
Q And she was able to complete that, correct?
A That's correct.
Q And that's why you do that, right? You put plaintiffs through hour after hour of testing so at the end of the day, you can put this line in here that they did so without too many complaints of pain, correct?
A No, no. I mean, we -- we test them for that long because we -- we need to, oftentimes, just to get the -- the data that we need. And it just happens to be another indication of their -- their stamina.
Q In the third paragraph, you write, and I quote, "In cases involving incomplete or delayed recovery from concussion factors unrelated to concussion very likely explain the persistence of symptoms." Did I read that correctly?
A Yes.
Q And then you list things that possibly account for Ms. Dillon's persistence of symptoms, correct?
A Yes.

Q And those are all possibilities, correct?
A That's right.
Q You don't know one way or another to a reasonable degree of professional probability what is causing Ms. Dillon's ongoing symptoms, correct?
A Well, I do have a sense that all -- all of the ones that I listed are relevant and I've -- there was some -- at least some evidence of those being present and relevant. Saying which ones precisely account for how much, I -- I don't think I can do that.
Q And that's why you list a bunch of different things, right? You can't say one way or another which one or which combination of them are actually causing the persistence of symptoms, correct?
A Well, I think they all are, but I don't know which ones account for how much.
Q All right. Let's go through them. The first one you list is, "Pre-existing anxiety and mood disorders," correct?
A Yes.
Q Do you have an opinion one way or another as to whether Ms. Dillon had preexisting anxiety and depression?
A Yes. I do think she had those.
Q Okay. And preexisting mental health disorders

like anxiety and depression, those are risk factors for persistent symptoms after a concussion, correct?

A That's correct.

Q So if you have a patient with preexisting anxiety under depression, then it's more likely that said patient is at a risk for persistent symptoms after a concussion, correct?

A Correct.

Q I know you're not a neurologist, but I think we talked about this. You think it's more likely than not that Ms. Dillon did have a concussion as a result of the collision, correct?

A Yes.

Q Okay. Concussion definitionally is a mild traumatic brain injury, correct?

A Correct.

Q Okay. So part of the basis of your opinion here as you looked at everything is that Ms. Dillon suffered a concussion in the collision, correct?

A Yes.

Q And if we're to accept that Ms. Dillon had preexisting anxiety and depression, then we have to also accept that it's more likely that Ms. Dillon was at risk for persistent symptoms from the concussion she suffered in the collision, correct?

A Right. And oddly, but -- but accurately, not because her brain was damaged.

Q Sure. But in other words, if we accept that Ms. Dillon had preexisting anxiety and depression, she would be more susceptible to persistent symptoms from a concussion, correct?

A Yes. Psychological symptoms. Yes.

Q Okay. Because a concussion could potentially exacerbate any preexisting mental health disorders like anxiety or depression, correct?

A Well, it's unclear that it's the concussion doing that as opposed to just having gone through an accident or something.

Q All right. And again, just kind of like the somatic condition we were talking about before, the trigger for that is still the collision, correct?

A Yeah. Proxy. Yes.

Q Okay. And actually, I think most of Ms. Dillon's treating doctors found that her anxiety and depression may be contributing to her prolonged recovery from her incident-related concussion, correct?

A Can you restate that? Sorry.

Q Sure. In your record review, did you see whether any of Ms. Dillon's treating medical providers opined that anxiety and depression may be leading to the

persistence of concussion symptoms that Ms. Dillon had after the incident?

A Oh. Yeah. And -- and in fact, were being mistaken for concussion systems -- symptoms.

Q Okay. Right. And just because the recovery is prolonged does not mean it's not related to the incident, correct?

A That's correct.

Q One person may recover faster than another, correct?

A That's correct.

Q But in any case, they're still recovering because they suffered an injury, correct?

A Yes.

Q Okay. Do you agree that mental health problems are quite common following a mild traumatic brain injury, correct?

A Yeah. Yeah. I would probably say they're not uncommon.

Q Okay. Going back to your list of possibilities here, you bring up symptom exaggeration as an explanation for Ms. Dillon's ongoing symptoms, correct?

A Yes.

Q You also bring up litigation, correct?

A Yes.
Q Is that why you think Ms. Dillon is malingering?
A I think it's a reasonable possibility.
Q Okay. You think she's lying because of her lawsuit, correct?
MR. KING: Object to the form.
THE WITNESS: No. I wouldn't say it that way.
BY MR. LADUCA:
Q Okay. To be clear, your opinion is she is malingering, correct?
A No.
Q Okay. What -- let -- okay. And I know there is a difference when we talk about feigning, malingering, exaggerating. So in terms of that concept, without getting into too much detail, can you succinctly tell me what your opinion is to -- as to Ms. Dillon?
A With regard to malingering?
Q Yes.
A My opinion is that there is objective evidence that she is exaggerating her symptoms, and that -- that because of that there -- there's an elevated probability that she's malingering, given the context that involves a substantial incentive. But I can't say that I know

she's malingering. No.

Q Can you say to a reasonable degree of professional certainty that she is malingering?

A I don't know. I can't -- I can't do that either.

Q Okay. Can you say to a reasonable degree of medical certainty that she is exaggerating her symptoms?

A Yes.

Q Okay. So if we get to trial on this, as far as you're going to go, is that she is exaggerating her symptoms?

MR. KING: Object to the form.

THE WITNESS: Well, I think I would say what I just said about the elevated probability that there are -- there's compelling evidence that suggests that she might be malingering, and I might describe what those things are. But no, I'm not -- I'm not going to say anything substantively differently than I just said, for sure.

BY MR. LADUCA:

Q Right. And the problem -- and you've done this before, doctor. The courts require that your opinions be to a reasonable degree of professional or medical certainty or probability. So you can't give that opinion you've just told me as to malingering. You

can give it as distinct symptom exaggeration.

So, that is going to be your opinion along with other things. But the core of your opinion is going to be that she is exaggerating her symptoms, correct?

A That's correct.

Q Okay. Let me ask you something generally. Bring up litigation as a reason for Plaintiff's malingering, and I know you're saying she's not malingering. I'll use that term. I can try and change it to feigning as we go here -- go through here, or exaggerating her symptoms. And almost the same thing. Well, let me ask it a different way.

You see that as an incentive for her to exaggerate her symptoms, right? Her lawsuit?

A Yeah. And it's not just monetarily. There's -- there's psychological reinforcing and -- and incentivized things too.

Q Right. And don't you have the same sort of incentive though to give opinions from your refer -- give opinions that support your referral source?

A Do I have -- say that again? Sorry.

Q Sure. You've written before that forensic practitioners have a bias to their referral source, meaning the person that sent them the examinee or the

person that's paying them, correct?

A Well, I -- I think -- I don't recall writing it that way. I -- I think it's a -- it's a -- a bias that we need to be aware of.

Q Okay. You literally have an incentive for personal gain if the defense continues to hire you to give opinions about symptom exaggeration and malingering of plaintiffs, correct?

A It -- it -- I guess indirectly. I -- I have the same payment coming from other sources too. And so far, I have no indication that my opinions about malingering have had anything to do with my -- getting retained.

Q Right. But if we're going to scrutinize plaintiffs like you do in terms of outside incentives to exaggerate or lie or malinger, shouldn't we apply the same scrutiny to a defense expert who's being paid by the defense bar?

MR. KING: Object to the form.

THE WITNESS: Well, I think we certainly have to be held accountable for biases that might be entering into our judgments.

BY MR. LADUCA:

Q Okay. And we've looked at your CV. Your entire career has been built on malingering, feigning,

exaggerating symptoms and the law, correct?

MR. KING: Object to the form.

THE WITNESS: Well, the -- my publications have been devoted to making sure we're doing this correctly and not misidentifying people.

BY MR. LADUCA:

Q Okay. If we look down, going back to your report. I forget where we left off. So there is a paragraph where you spend a sentence stating that your interpretation of Ms. Dillon's testing revealed that the testing was mostly normal and in some areas even above average, correct?

A That sounds right.

Q I believe it's the last paragraph there. Yeah. It goes onto the next page.

A So the last paragraph on page 14?

Q Sorry. 13 onto 14.

A Oh. 13. Okay. I see. Yeah.

Q And just to summarize, again, since we've kind of lost it, that paragraph starts with you basically summarizing Ms. Dillon's testing results and stating that, "the results are mostly normal and in some areas even above average," correct?

A Yeah. That's one of the things that I described. Yes.

Q Okay. And then you go on in that paragraph into what you call, and I quote, "The most significant aspect of her profile," correct?

A Yes.

Q And to you, the most significant aspect in her psychologic -- is her psychological presentation, correct?

A That's right. Because the neurocognitive scores, though variable, didn't suggest anything pathological.

Q And your interpretation of Ms. Dillon's psychological profile is that she, and I quote, "Very likely has exaggerated her symptoms," correct?

A That's right.

Q And that, in your mind, in your own words, raises the probability of malingering, correct?

A That's right.

Q But as you've stated before, you're not a mind reader. You don't know why she would be doing something, correct?

A No. I have to use the -- the best state of the science that I have.

Q Are you coming -- are you using the, and you mentioned it before, the SLICC criteria to come to your opinion that there is a probability of malingering?

A Yes. Not what -- the -- the 2020 version. Yeah.

Q What's required under the SLICC criteria to get to a probability of malingering?

A Well, yeah. I mean, there's a bunch of different ways of looking at it. It's a very, in my opinion, cumbersome set of criteria. But one of the things that was -- is required, and the -- the one that's most psychometrically sound, is the presence of two indicators, two objective indicators in this context, again, of this substantial incentive to do so. But there's also these compelling inconsistencies and market discrepancies considerations. So I don't -- I don't think she fits all of those.

So I -- I think she does have -- well, I don't think she has. I know she has evidence from two reliable sources that she's exaggerating her symptoms. But like I said earlier, I -- these raise the probability, but I don't think they -- they should be equated with a finding of malingering.

Q All right. The two types of evidence that you're using to get to the SLICC criteria, what are your two pieces of evidence?

A Well, there's actually more than two. But --

Q Sure.

A The scales from the MMPI and scales from the -- oh, I'm sorry. The MMPI-2-RF and the BHI 2 would be the -- the central parts to that.

Q And is there any other testing that you're using as a positive result?

A Oh, the -- the SIMS.

Q Okay. You'd agree that even positive testing results under the SLICC criteria only generate classifications of probable malingering, correct?

A Classifications of malingering probability. Yes.

Q Right. It's a suggestion of malingering, correct?

A It's a what? Sorry.

Q Suggestion.

A I don't think I follow. A suggestion -- what -- what's a suggestion?

Q The test results lead you to a suggestion of a classification of malingering.

A Yeah. I -- I would -- I think it's probably more than that. It's an indication.

Q Okay. And we've talked about this before a little bit, but possible malingering was dropped as a category under SLICC because it lacked diagnostic utility, correct?

A Yeah. It was not helpful.
Q Assuming that the possible malingering category was still there, would Ms. Dillon's test results have fallen into the possible or probable category?
A You know, I don't recall. I think it probably would've fallen into probable.
Q Okay.
A But I --
Q It didn't -- sorry.
A Oh, I haven't looked at the 99 criteria in a while.
Q Okay. It definitely is not falling into definite, correct?
A I don't believe it would.
Q Okay. In the next paragraph, you start with, "Ms. Dillon's presentation it's inconsistent with concussion in a number of ways." Did I read that correctly?
A You did. And it's a misleading sentence in my opinion. I -- I should have said inconsistent with post-concussive syndrome.
Q Okay. Let's go back to your record review, and maybe your explanation will fall in line with what I'm about to show you, but page 2 --

A Yes.

Q -- of your record review, and specifically the first paragraph next to "Inova Sports Medicine."

A Yes.

Q There, you're looking at and summarizing a record from August 14th, 2019, correct?

A Yes.

Q And in that paragraph, about halfway down, starts near the right of the paragraph, you write, "The immediate symptom was neck pain and she did not have dizziness, amnesia, or loss of consciousness," correct?

A That's correct.

Q Let's look at -- I didn't realize I was still sharing, but now I've got up what's been labeled as Exhibit 4. I will zoom in for you.

A Thank you.

Q This is the record we were just talking about, correct?

A I believe so.

Q Okay. And under the "Subjective" description, the quote that you purported to quote starts here, and how it actually reads is, "Immediate symptoms were reported as including confusion for a few moments and neck pain." Did I read that correctly?

A I reported as confusion for a few moments and

neck pain. Yes.

Q Okay. You did not put in your record review that Ms. Dillon reported confusion for a few moments in your records -- in your record review, correct?

A I did not.

Q Why not?

A Why not? I don't remember not doing that. Because I, like I said, I acknowledged that she experienced an alteration of consciousness and that she likely had a concussion.

Q Mind reader -- maybe you're a mind reader. Confusion for a few moments is also known as an altered mental state, correct?

A Yes.

Q An altered mental state, even without the loss of consciousness, is a sign of a traumatic brain injury, correct?

A It can be. It's -- it's tricky because you can have alterations of consciousness that don't involve concussion.

Q Correct.

A But certainly it is considered one of the -- one of the signs of concussion.

Q And if you look back at page 2 of your report, again, you're summarizing this record and you have a

laundry list, I'll call it, of current symptoms, correct?

A Yeah. In that same paragraph?

Q Yes.

A Yes.

Q However, if we look at page 2 of this record, there is a section called "Current Symptoms," correct?

A Yes.

Q And it states those are symptoms that Ms. Dillon was experiencing in the last 24 to 72 hours, correct?

A Yes.

Q And it states that in the 24 to 72 hours prior to this visit that you've cited in your report, Ms. Dillon was experiencing light sensitivity, correct?

A Yes.

Q And noise sensitivity, correct?

A Yes.

Q And visual difficulties, correct?

A Correct.

Q And all that was listed under physical symptoms, correct?

A Yes.

Q Why didn't you list those in your record review?

A I -- I tend to list the things that capture her presentation for me cognitively.

Q Okay. Well, there's a section called "cognitive symptoms," correct?

A Yeah.

Q And you're going to testify to Ms. Dillon's cognitive symptoms stemming from the collision, correct?

A That's right.

Q But you didn't list a single one of those symptoms in your record review, did you?

A (Reading to self.) Well, I do have in addition to clinical signs and symptoms of concussion.

Q Right. But you listed out, irritability, sadness, anxiety, sleep difficulty, all of the -- you listed one, two, three, four, five, six, seven, eight, nine different symptoms in your record review, correct?

A Yes.

Q But you didn't list a single one of the cognitive symptoms that were listed, correct?

A That -- yeah. That's -- that appears to be correct.

Q Why not?

A I don't know. I -- maybe it's because I -- I felt like I had captured her presentation or those symptoms were described somewhere else already.

Q All right. Well, the record indicates, "in the 24 to 72 hours prior to this visit, Ms. Dillon was experiencing cognitive symptoms, including mental fogginess," correct?

A Yes.

Q "Feeling slowed down," correct?

A Oh, yes.

Q "Trouble concentrating," correct?

A Yes.

Q "And memory challenges," correct?

A Correct.

Q But none of that made it into your report when you were reviewing this record, correct?

A No.

Q Okay. Let's go back to your conclusions on page 14. In that paragraph -- with the sentence that you started off with that you don't like anymore. In that paragraph, you opine that, "Ms. Dillon's presentation is inconsistent with concussion in a number of ways." And one of the problems you have with Ms. Dillon's presentation is that, "her symptoms worsened sometime after the collision," correct?

A I believe more than once.

Q Okay. And you feel that's not a normal presentation, correct?

A Not if you're looking at neurologic consequences of concussion. It -- it can be a part of the sequence of events after a concussion involving non-neurologic issues. Yeah.

Q You agree that patients may not notice mental impairment until attempting to return to their pre-injury work status, correct?

A Yes. I agree with that.

Q Okay. And that's a normal thing because once they get to work, there are the additional stressors that work can bring that are placed upon the injured patient, correct?

A That can be, and it would all come down to when they returned or whatever that -- that thing was that they were starting to do that they hadn't been doing. I would expect them to have a -- a potential worsening of symptoms if it was within the first couple of months. But after that, you wouldn't.

Q All right. Well, Ms. Dillon did report to you that her symptoms worsened after she returned to work, correct?

A Yes.

Q And that's reflected in her treatment records with Dr. Womble, correct?

A That's right. But I -- as I -- that -- that

the -- the unusual element there is that they got worse in December, which is many months after the accident.

Q In this paragraph, you do state that your testing revealed Ms. Dillon has anxiety and depression, correct?

A That's right.

Q But reading your report, tell me if I'm wrong, it looks to me like you attribute Ms. Dillon's anxiety and depression to an eating disorder and her being raped in college, correct?

A I think those are two significant considerations for those conditions. Yes.

Q Okay. You bring up an adjustment disorder a couple of times in this report. What is an adjustment disorder?

A It's basically a -- a psychological reaction that often involves anxiety and/or depression related to a stressor of some kind. But it's also defined by the fact that when the stressor is absent, the symptoms go away.

Q Do you believe that Ms. Dillon suffers from an adjustment disorder?

A I don't think she does now.

Q Do you believe that at any time after the incident, she suffered from an adjustment disorder?

A I think it's reasonable to assume that.
Q Okay. And when she suffered from it, in your opinion, that would've been related to the incident, correct?
A Yes.
Q Okay. You've not seen a single record where a mental health professional actually diagnosed Ms. Dillon with anxiety or depression prior to the incident, correct?
A Not a formal diagnosis. No.
Q Okay. And actually all you've seen would be a self-report of anxiety or depression, correct? Before the incident?
A Yeah. I've seen records capturing that.
Q Right. But not a medical provider with a diagnosis of anxiety or depression, correct?
A Just medical providers reporting that that was worth reporting.
Q Reporting that Ms. Dillon told them that, correct?
A Right.
Q Okay. You've not -- you've not seen a single record to indicate that Ms. Dillon ever had formal psychiatric or talk therapy prior to the incident, correct?

A I haven't seen a record. She said she had some, but I haven't seen the record.

Q Okay. You've not seen a single record to indicate that Ms. Dillon was ever prescribed depression or anxiety medications prior to the incident, correct?

A I don't believe so.

Q The collision occurred directly between the time that Ms. Dillon was seemingly asymptomatic and the time she started reporting symptoms, correct?

A Seemingly.

Q Do you think the collision had anything to do with her going from asymptomatic to symptomatic?

A Yes.

Q Okay. Do you know what the publication Neuropsychological Assessment is?

A Yes. I think -- I mean, vaguely.

Q Okay. That's Lezak's book, which is accepted as the Bible of neuropsychology, correct?

A Sorry. I -- I thought you were referring to a journal or something.

Q No.

A Yeah.

Q That is Lezak's book, correct?

A Yes.

Q And that is widely accepted as the Bible of

neuropsychology, correct?

A It used -- it used to be.

Q Okay. In that publication, Lezak writes that, Emotional distress, fatigue, heightened irritability, depression, and anxiety are all common symptoms after a traumatic brain injury, even a mild one. Do you disagree with that?

A No.

Q In the last line, you say, "It's not surprising" -- of your report. Sorry. You say that it's -- not the last, last line. Let me start over. In the last line of that paragraph, you states, "It is not surprising that Ms. Dillon has not been diagnosed with PTSD," correct?

A Yes.

Q And I believe your reasoning for that is because at that time, she had not undergone any formal psychiatric evaluation, correct?

A That's right.

Q Okay. Do you believe that Ms. Dillon has PTSD related to the collision?

A No.

Q Okay. Do you know what medical gaslighting is?

A No.

Q The next paragraph there, you make some observations in your report regarding Dr. Hebda's evaluation of Ms. Dillon. Bottom of page 14.

A Yes. Okay. Thank you.

Q In that paragraph you talk about Dr. Hebda's findings, correct?

A Yes.

Q Okay. You said you know Dr. Hebda professionally. Do you have any opinions as his capability -- of his capabilities as a neuropsychologist?

A No.

Q Okay. From my read of the two reports, other than your personality testing and exaggeration opinion, you two don't actually really disagree on much, correct?

A I -- I would agree with that. There's a lot of overlap.

Q Okay. Dr. Hebda found that Ms. Dillon had mild deficits in visual attention and alternating attention, correct?

A Yes.

Q You didn't find the visual attention deficits, but through your evaluation, you did find that Ms. Dillon had alternating attention deficits, correct?

A Well, I found a score, but that's different than

concluding that she actually has a deficit in that -- that (indiscernible) 1:48:40.1. So we -- we would just be interested in seeing one -- more than one metric suggesting that -- that there was a problem.

Q Okay. You found a score that was lower than her baseline, correct?

A Yes.

Q Okay. How is that not a deficit?

A Well, the score itself isn't the deficit. It's -- it's an indication of one. So you'd want to try to confirm that with other -- of -- of -- other evidence of that same problem.

Q Okay. Well, I guess it's fair to say you found an indication of a deficit with Ms. Dillon when it comes to alternating attention, correct?

A Yes.

Q Okay. What is the difference between cognitive testing and mental health or psychological testing?

A The focus, I guess. I mean, I guess the -- the nature of the tests are different too, but psychological tests tend to be inventories.

Q Right. Cognitive testing tests for actual deficits in cognition, correct?

A Yes. You -- you ask them to do certain tasks

and you look for problems in that task.

Q Mental health, psychological, personality testing looks for mental health diagnoses or indications, correct?

A Right.

Q Mental health testing does not diagnose actual organic injuries or problems, correct?

A It does not diagnose them. No.

Q Okay. They're just used to interpret why a patient may be complaining of a given symptom like pain, correct?

A Yeah. Or -- or what it's like for them to have it.

Q Right. And of course, the patient could actually be telling the truth, correct?

A Yes.

Q And we've established that pain is a common symptom of patients with a traumatic brain injury, correct?

A Yes.

Q Okay. And the MMPI is a mental health test, correct?

A Yes.

Q As is the BHI 2, correct?

A Yes.

Q As is the SIMS, correct?
A Correct.
Q The word "malingering" is literally in the name of the SIMS test, correct?
A Correct.
Q And according to the SIMS manual, a determination of even probable feigning using the SIMS should not negate the possibility of genuine disability or disorder, correct?
A That's right.
Q Meaning that even the suggestion of probable feigning or malingering does not mean that a patient does not have a genuine disability or disorder, correct?
A That's right. That's right.
Q Meaning that the test itself cannot actually distinguish between actual versus feign symptoms, correct?
A Repeat that last part. Sorry.
Q The test itself cannot actually distinguish between actual versus feign symptoms, correct?
A The test itself would -- I guess, again, it -- it provides empirical support for the -- an elevated -- sorry. Elevated probability of feign, the symptomatology. But by itself, the score isn't going to be able to say, yes, I -- I know that it's actual versus

feign.

Q And you've actually written on the SIMS and said it needs further validation when paired with a symptom combination scale, correct?

A Yes.

Q Okay. And the test we talked about, the MMPI, BHI 2, SIMS, all of those are for mental health issues rather than for actual cognitive deficits, correct?

A No. I mean, they're not necessarily PVTs, but they're certainly useful for cognitive complaints.

Q In terms of feigning or malingering, but not in terms of actual showing of cognition deficits, correct?

A Oh, I see what you're saying. No. None of those would be used to establish the presence of a neurocognitive disorder.

Q Right. And you agree that you primarily rely upon mental health testing to come to your opinions in this case, correct?

A No, I -- I -- my opinions are based on the entire evaluation of neurocognitive and psychological testing.

Q All right. Well, if we looked at your testing section, which starts on page 11, you dedicate almost an entire page to the SIMS, the MMPI, and the BHI 2,

correct?

A Yes.

Q Did you utilize the SIRS interview technique?

A No.

Q Why not?

A Well, first, I'm not sure I know what you're -- you're referring to with the interview technique. I mean, I -- I started with an open-ended questioning style and then get a little bit more structured as I went, and then started doing testing.

Q Do you know what the structured interview of reported symptoms is?

A Yeah.

Q Okay. You didn't utilize it with Ms. Dillon though, correct?

A I did not.

Q You agree that studies have found that the SIRS is a better test when trying to determine feign symptoms than is the MMPI, correct?

A Yeah. Particularly in psychosis, and that really wasn't an issue here.

Q Okay. During your testing, did Ms. Dillon miss any very simple items that were unexpected for someone with a TBI?

A No.

Q Did you employ any two-choice testing items?
A Yes.
Q How'd she do on that?
A She did okay.
Q She passed?
A Yes.
Q Did you perform any recognition testing?
A Yes.
Q How'd she do on that?
A She passed.
Q Did you report -- did you perform any recall testing?
A Yes.
Q She passed?
A Yes.
Q So she performed well on both recognition and free recall testing, correct?
A That's right.
Q How many performance validity tests did you administer to Ms. Dillon during your testing?
A About five.
Q Which ones?
A Let's see. (mumbling) The word choice test, logical memory recognition, visual reproduction recognition, reliable digit span, and then the RBS and

the FBS scales from the MMPI-2. So I guess that's six.

Q How'd she do on those?

A Say again, sorry?

Q How did she do on those?

A The -- the first four, she did fine. And the last two, she did poorly.

Q How many symptom validity tests did you administer to Ms. Dillon during your testing?

A Let's see. There's -- there's six from the SIMS, two from the BHI, and nine from the MMPI-2-RF.

Q How many did she pass on the BHI?

A And just for the record real quickly, for -- on the MMPI-2-RF, some of those are to -- to identify indications of responding in the opposite direction where you're -- you're under-reporting. So I include -- I included those.

Q Right.

A The BHI, one, I believe.

Q She passed one and failed five?

A Oh, no. I'm sorry. On the BHI, there's two.

Q Oh, what are -- so one and one?

A Correct.

Q On the test with six, what was the pass-fail?

A Three. And that's an error in my report as well. Well, no. Actually that's not an error now that

I think about it. It was four of six.

Q Four of six?

A Or above the -- or above the cut fail.

Q Four of six cutting. Okay. And on the MMPI?

A Of the ones dedicated to over-reporting, three of five.

Q How many of Ms. Dillon's test results were consistent with genuine symptoms?

A How many symptoms were consistent with genuine symptoms?

Q How many test results were consistent with reporting genuine system -- symptoms?

A It's difficult to -- to conceptualize it that way because the scales look for unusual combinations and elevations that can't be explained by genuine symptoms. So just their presence by themselves is -- is the significant and statistically unusual thing.

Q And that it's subject to your interpretation, correct?

A Well, the elevation isn't. The elevation is based on research that tells you what that score needs to be to be 90 or above percent accurate.

Q What is a cut score?

A Sorry?

Q What is a cut score?

A Oh, it's -- it's the score above or below which you can establish group differences.

So if you're comparing, for example, a group of people who have a brain injury with those that don't, there are tests out there that we give that can distinguish one group from the other based on performance on that test. And yet research has to be done to figure out, well, what -- what level of performance is necessary to do that?

Q What is the standard error of mean?

A Well, the standard error of mean is -- the standard error of the mean. It's such a good question. I've thought about that a while. I think that's the measurement error -- no. That's the standard error of measurement. The standard error of the mean -- I -- I want to say that's something like standard deviation, but I can't recall right now.

Q How many of Ms. Dillon's scores were there -- were within one standard error of mean to a given test cut score?

A I don't know that.

Q Did you categorize any test scores as indeterminate or did you just rely on everything?

A I relied on everything.

Q Did you ever consider that your test results

were inconclusive?

A I don't think I ever thought that they were inconclusive. No.

Q Did you even have an indeterminate classification set for your evaluation?

A No.

Q You agree not having an indeterminate classification is inherently flawed, correct?

A It's -- right now -- it's most helpful in research to -- to start thinking those ways, but right now in clinical and forensic cases, I don't think it's helpful.

Q Okay. Well, you've written that having an indeterminate classification is inherently flawed, correct?

A It has flaws.

Q You didn't have one with Ms. Dillon, correct?

A Well, I mean, I -- you have to use the entire picture. You have to over -- you have to work with the flaws and the strengths and come up with an opinion.

Q All right. Well, I'm just -- you yourself have advocated for all practitioners to utilize an indeterminate classification, correct?

A Yes.

Q The MMPI does not utilize an unclassified

group, correct?

A Yeah, there's really -- there's hardly anything that does right now.

Q So by your own logic, then the test is currently flawed, correct?

A Well, yeah. They're all flawed to some degree, but they're not so flawed that you can't use them reliably and validly, in my opinion.

Q What were the measures that you would've had to find, and it may be none since you didn't use an indeterminate classification for your evaluation, to be inconclusive?

A Well, I -- I can only -- I only know of the SIRS has an -- SIRS-2 has an indeterminate range.

Q Okay. You agree -- you agree that there are some cases that are too close to call without substantial error, correct?

A Too close to call without substantial error? I don't think I know what you mean.

Q Meaning that if -- based on a set of data that can be interpreted one way or another, a hundred times, they could come out 40 ways, sometimes 60 ways the other, so it's inherently flawed. And you can't make a determination one way or another without substantial error in the interpretation.

MR. KING: Object to the form.

THE WITNESS: Oh, I think I understand what you're saying. I think behavioral science is -- yeah. Has that probable -- that problem maybe more than other areas of science.

BY MR. LADUCA:

Q Okay. And that's why you use an indeterminate classification, correct?

A Yeah. Ideally.

Q What is a false alarm in terms of testing?

A I don't -- I don't know what you mean.

Q Okay. Well, you wrote an article that stated -- that stated, two studies into the MMPI-2-RF have shown that the test has a false alarm rate of anywhere from 10 to 36 percent. Does that refresh your recollection?

A I don't. Did I write that with someone?

Q You did.

A I don't recall that.

Q Okay. So you don't know what a false alarm in terms of testing is?

A I mean, I'm guessing -- I -- I would -- I'd be guessing, but I may -- maybe a false positive.

Q Okay. You agree that differing cut scores can result in the different interpretations of a study,

correct?

A I'm sorry. Maybe I'm getting tired, but can you restate that?

Q What was your cut score for the MMPI test that you administered?

A Oh, there are various ones. So the -- the ones recommended in the manual.

Q Okay. And even the manual, when it's looked at, the standard errors of the mean for the MMPI-2-RF are substantial, correct?

A They can be, it depends on the scale. I don't remember them specifically.

Q And what does that mean?

A What does it mean?

Q Yeah.

A What does what mean?

Q What does -- the standard error of mean and -- for the MMPI-2-RF being substantial, what does that mean?

A Oh, that there is a range of scores that keep it from being, you know, a hundred percent precise. That score is meant to represent a -- a range of scores, not -- not that specific score a hundred percent of the time.

Q You agree that the MMPI-2-RF scales do not

overlap with each other, but they overlap with clinical scales, correct?

A Yes. That's true.

Q Which means what?

A That they tap into the same things some of the time, but it does -- that doesn't take away from the utility of those validity scales as validity scales.

Q Actually, you wrote that it confounds the interpretation and classificatory utility, correct?

A Did I write that with someone else too?

Q You did.

A I don't recall writing that. And I think it's technically true. I would say that there has to be something we consider in research as we continue to try to make these measures better. But the validity scales work, especially when they're elevated. Those elevated scores don't correlate very well with the clinical scales.

Q Well, again, you wrote that the symptom validity scale and the MMPI is prone to false positive errors, correct?

A Yeah. Research -- I'm not sure what -- what date that is you're reading from. But research has -- has subsequently shown that the FBS, or it's called SVT now, I think that's probably what you just said, is less

problematic than the initial alarms suggested.

Q Okay. But the problems show themselves more in testing of women, correct?

A They did. But again, there's research showing that actually there isn't a -- a reason to be worried about those scores. So women -- women do score a little bit higher, but the cut scores are really largely unaffected.

Q There was a study by Butcher in 2008, which found that 44 percent of eating disordered women were found to be feigning based on the SVS cut score, correct?

A I vaguely remember that. I know the study you're talking about.

Q Okay. And Ms. Dillon does have an eating disorder, correct?

A Yes.

Q Did you take that into consideration at all when you administered the MMPI?

A Yes. She -- the -- the score is still elevated.

Q Okay. A study in 2009 by Victor found that 40 percent -- 41 percent of genuine responders failed at least one embedded effort measure in a battery of neuropsychological tests. Do you recall that?

A I do.

Q Okay. You actually adopted a fall through the ICE approach with Ms. Dillon, correct?

A Not -- not really. Again, there's -- there's -- these tests are developed to really strongly avoid a false positive error, meaning they're designed so that they don't capture someone or label someone as feigning unless the odds are very, very high that they are. And they do that at the expense of missing some people who really are feigning. So it's this balance, what we call specificity and sensitivity.

So that's -- that's why when you find that there's evidence of an elevation on a validity scale, that finding is very unusual statistically. So it doesn't -- when you compare it just quantitatively to other things, it doesn't really fit. It's really the -- the quality and the unusualness of that finding that's so important.

Q Well, it's not that -- it's not that unusual when 41 percent of genuine responders are failing the test, correct?

A No, that's right. And she didn't fail any of mine.

MR. LADUCA: Okay. Let's take a five-minute break.

THE WITNESS: Can -- do you have any ideas about how much further we have?

MR. LADUCA: I probably have another hour.

THE WITNESS: Another hour?

MR. LADUCA: Yeah.

THE WITNESS: Okay. Okay.

THE REPORTER: Without objection, we are now going off the record. The time is 3:09 p.m., Eastern Standard Time.

(Off the record.)

THE REPORTER: Without objection, we are back on the record. The time is 3:15 p.m., Eastern Standard Time.

BY MR. LADUCA:

Q Doctor, on page 15 of your report, end of the paragraph that starts at the top, it states, "In short, Ms. Dillon's profile suggests that her cognitive functions are at or above expectations, contrary to the definition of neurocognitive disorder." Did I read that correctly?

A Yes.

Q But being at or above expectations is not the diagnostic criteria for a mild neurocognitive disorder, correct?

A No. I mean, it's -- it is -- it's contrary to what you would expect to see in someone who has one.

Q All right. According to the DSM, for a mild neurocognitive disorder, you only need evidence of modest cognitive decline from a previous level of function, correct?

A That's right.

Q Meaning there has been a decline from your pre-injury status, correct?

A Correct.

Q So if you're super high-functioning and then declined to simply high-functioning, that would be a decline, correct?

A Yes.

Q Okay. And that decline can come in any cognitive domain, correct?

A That's right.

Q It can be in complex attention, executive function, and learning, and memory, language, perceptual memory, social cognition, anything, correct?

A That's right.

Q And is it your testimony today that Ms. Dillon has had no decline from her baseline due to her injuries?

A Yeah, I don't -- we -- I don't have evidence

of that.

Q Okay. You did reveal through testing a deficit in alternating attention though, correct?

A I -- a low score.

Q Lower than her baseline, correct?

A That's right.

Q So if it's lower than her baseline, that's a decline, correct?

A Only if the base rates would support that, and I don't -- the base rate research out there shows that perfectly healthy people of her IQ would get a couple scores that are low. So I didn't find the evidence to be very compelling that she had a neurocognitive disorder.

Q Okay. The criteria states that a mild neurocognitive disorder does not need to interfere with activities of daily living, correct?

A That's right. It would be particularly mild not to, but yes, it is in the criteria.

Q Let's go to your diagnostic impressions. The first one is, "Possible concussion in 2019, resolved." Correct?

A Yes.

Q Okay. And as we've talked about before, it's actually your opinion that more likely than not she

sustained a concussion in the collision, correct?

A Yes, that's true.

Q The next one is, "Possible postconcussive syndrome in 2019, resolved." Correct?

A Correct.

Q It's also your opinion that she suffered postconcussive syndrome due to the incident, correct?

A Yes.

Q Okay. Third one is, "Neck strain/whiplash." Correct?

A Yes.

Q You're not giving orthopedic opinions at the trial, correct?

A No. I'm just reporting what was in the record.

Q Fourth one is, "Pre-existing headache, anxiety, eating disorder, and profound hypokalemia." Correct?

A Yes.

Q And when you say "pre-existing," you mean pre-existing the collision, correct?

A Yes.

Q Let's start with hypokalemia. You are not a nephrologist, correct?

A Correct.

Q So you're not going to be giving any opinions at trial regarding hypokalemia or the effects thereof, correct?

A That's correct.

Q Okay. We've talked a bit about the anxiety. What is your basis for saying that she had pre-existing anxiety?

A Yeah. The report that she had it, primarily, but also the eating disorder, eating disorders characterized by significant levels of anxiety and -- and the -- other things as well, like obsessive compulsive and stuff, things like that.

Q What is your basis for saying that she had pre-existing headaches?

A The record and her report, I believe. I think she told me she had headaches.

Q Okay. You talk about Ms. Dillon -- Ms. Dillon's eating disorder. You understand that Ms. Dillon suffered from an eating disorder from her early teenage years through about the age of 30 when it went into remission, correct?

A That's my understanding.

Q Okay. And it's your understanding that Ms. Dillon's eating disorder has returned since the collision, correct?

A Yeah.

Q Okay. And in your report, you don't say one way or another, but a traumatic event like this collision is a typical trigger for the eating disorder to return, correct?

A Yeah, it could be. I mean, it's -- it's hard to know. Again, a lot of it would come down to timing as well. I think it's reasonable to assume that it has -- there's a connection there, that she had -- had some vulnerability to that.

Q Okay. You said the only defense report that you've seen to date is Dr. Trachman's, correct?

A Yeah, I just -- I saw that I -- that it's there. I really didn't read it.

Q Okay. So if I asked you if you agree or disagree with any other defense expert opinion, your response would be, you don't know what they're opining t?

A That's correct.

Q You've never talked to any of Ms. Dillon's family members or friends, correct?

A That's correct.

Q Okay. We discussed your publications at the beginning of this deposition and one of them was titled An Overview of Malingering and Deception in

Neuropsychiatric Cases, correct?

A Yes.

Q And that was just published at the end of last year, correct?

A Yes.

Q And the entire basis of that article was to layout detection strategies for malingering, correct?

A Yes, that sounds right.

Q I'm going to pull up what's been marked as Exhibit 5. This is the article I just referenced, correct?

A Yes.

Q Okay. In the abstract, you write, "Forensic practitioners must shoulder special responsibility when evaluating over-stated pathology, e.g., malingering, as well as simulated adjustment. Such determinations can modify or even override other clinical findings." Did I read that correctly?

A Yes.

Q What is a clinical finding?

A Basically, the identification of a diagnosis or symptoms that are worth noting clinically.

Q And according to your article, if you determine that a patient is malingering or feigning symptoms, you may just override clinical findings,

correct?

A I think -- I think that's possible. It could happen. I think what we're trying to say there is that how significant this endeavor is, that you'd have to take it very seriously because it could possibly do that.

Q In the introduction here -- give me one second. You write, "For instance, the determination of malingering may shape all other conclusions in a forensic consultation." Did I read that correctly?

A Yes. I don't know that I wrote that, but I don't disagree with it.

Q Okay. So to you, a malingering determination or an exaggerating determination may be the most important thing in a forensic consultation, correct?

A Sure.

Q You stated, it literally can shape all other considerations, correct?

A Right.

Q Okay. In the last line, on the first page and into the second page, you used the term "overstated pathology", correct?

A Yes.

Q And you -- and you explained that overstated pathology is a new term for what used to be called

faking bad, correct?

A Yes.

Q And so faking bad was just rebranded with overstated pathology, correct?

A Yes.

Q I -- it does sound better, but they're the same concepts, correct?

A That -- that's why it was changed.

Q All right. And then you have a section on overstated pathology, correct?

A Yes.

Q What is overstated pathology?

A And that's another reason I think it was changed because it's pretty self-explanatory. I mean, it -- it's -- it's engaging in an overrepresentation of illness or symptoms.

Q Okay. What is the difference between feigning and malingering?

A Malingering is a type of feigning. Feigning doesn't really imply why that you're doing it.

Q Whereas malingering has an external motivation, correct?

A Right.

Q Like litigation, correct?

A Correct.

Q And we've talked about this before, but whether you determine it's feigning or malingering, both involve gross exaggeration or fabrication, correct?

A Yes.

Q Okay. And we might not need to go through this because I think we already have. On this page here, we talked about the fact that the DSM-5 gives malingering a V code, correct?

A Oh, yeah.

Q Okay. Down at the bottom there, you cite an interesting study by Richard Rogers. Richard Rogers is your mentor, correct?

A Yes.

Q He also focused his career on malingering, correct?

A Yes.

Q He is the co-editor of the textbook you edit on malingering, correct?

A Correct.

Q And in the Rogers study, you cite, "more than 80% of the individuals evaluated did not appear motivated to malinger despite the presumed presence of an external incentive." Correct?

A That's right.

Q And of the 20 percent who were even possibly

malingering, Rogers only found that 3.1 percent definitely malingered, correct?

A Yeah. I can't remember what study that was. It might -- it's probably a criminal setting. But --

Q Yeah. The rest of the 20 percent only had signs of moderate deception, correct?

A That sounds right.

Q So even at that 20 percent, four out of five people didn't malinger, correct?

A In that setting, yes.

Q Okay. And in that setting, the people looked at were criminal defendants facing lengthy prison sentences, correct?

A Right.

Q And still facing lengthy prison sentences, a large majority of those people did not malinger, correct?

A That's -- yes. That's true.

Q And the point you make here, which I think is an important one, is that your words, "Clearly the presence of possible incentives is very different from the motivation to act on them." Did I read that correctly?

A Absolutely.

Q And just -- so in other words, just because

people have an obvious incentive to lie, it doesn't mean that people actually do lie, correct?

A That's absolutely correct.

Q Okay. So even though there's a lawsuit going on, the result of which may be compensation for Ms. Dillon, it does not mean that Ms. Dillon is lying in order to be compensated, correct?

A No. It's just a -- a reasonable possibility.

Q Okay. It's a possibility, correct?

A Well, in this case, it's a reasonable probability, but I -- I -- it's not -- it should not be equated with -- with, you know, with malingering, just like you read.

Q Okay. What is -- and this may be the same thing as an adjustment disorder, but you have a whole section here on simulated adjustment. So what is simulated adjustment?

A That's the inverse of malingering basically. It's -- it's presenting yourself as more well-adjusted than you really are.

Q Okay. Do you believe that Ms. Dillon practiced simulated adjustment at any point?

A I think she has in the past given her -- her resistance to accept therapy or seek it, but I didn't see anything that I could say that -- I don't have

anything empirical or objective. No.

Q And even if you did, it'd be a fallacy to wrongly extrapolate that if something is simulating -- simulated, everything is simulated, correct?

A No. Yeah. If something is simulated, it does not mean everything is. No.

Q Okay. I'll have to find it here. We talked about this a little bit before, and it's the last paragraph -- last paragraph here, last sentence. You wrote, "Finally, while likely unintentional, forensic practitioners may fall victim to allegiance bias, substantially modifying their scores on the psychopathy checklist revised to favor the source of their referral." Did I read that correctly?

A Yes.

Q Who was your referral source in this case?

A A law firm.

Q Okay. It was the defense, correct?

A The -- yes, the defense. Sorry.

Q And in almost 70 percent of the cases you work for, it's the defense, correct?

A In this setting, yes.

Q Okay. So while unintentional, you admit that even you may fall victim to allegiance bias, which favors the source of your referrals, correct?

A That's possible.

Q Okay. On page 31 of your article, you bring up detection strategies. And it's detection strategies for mental disorders. You said that Ms. Dillon did report rare symptoms to you, correct?

A I did say that? Is that what you said?

Q You did, yeah. You testified earlier that she did?

A Yes. Sorry. I -- I couldn't hear you.

Q And what were those again?

A Yeah. I don't remember. I don't have that written down. And I don't remember what I said earlier. Sorry. I'm getting a little tired.

Q Okay. She didn't report any varying symptom severity and improvement to you, did she?

A Any varying symptom severity?

Q And improvement?

A Well, she -- she reported that her symptoms kind of improved and worsened in ways that I wouldn't have expected them to.

Q All right. Let's go through some detection strategies for cognitive impairment. What is the floor effect?

A The -- the floor effect is a strategy for detecting cognitive -- feigned cognitive impairment.

Q Did you utilize any testing that utilized the floor effect with Ms. Dillon?

A Yes.

Q Did she miss any very simple tasks in her evaluations on the test with the floor effect?

A No.

Q Okay. So that would be a sign that she was reporting genuinely, correct?

A Or performing adequately.

Q Okay. What is substantially below chance performance?

A Well, we usually look at that in terms of two-choice forced -- forced choice testing, where you can -- you can derive a probability of having missed a certain number within, you know, a 95 percent probability, for example. So if -- if you're giving a test that's true-false.

Q Right. Ms. Dillon didn't fall below the 50 percent chance level during your testing of her, correct?

A No, she did not.

Q Which would also indicate that she was testing adequately or genuinely, correct?

A Yes.

Q What is the violation of learning principle?

A Something like performing worse on a test like recognition than on a more demanding task like free recall.

Q Right. And Ms. Dillon performed well on both the recognition and free recall testing that you administered, correct?

A She did.

Q So based on your own writings, Ms. Dillon didn't have any of the things that you point out. So how is it your opinion that she's exaggerating her cognition symptoms?

A Because there's compelling evidence that she is doing that when you -- when you ask her to describe it. So this happens occasionally. When the person takes the test, they -- they don't take it on testing. But when you ask them to describe the problems they have, they do embellish or exaggerate those -- those symptoms. And that's what I think is happening in this case.

Q All right. So you're relying on just what she told you then, not the testing results, correct?

A The objective scales that captured what she's telling me.

Q Okay. Because on your testing, she passed.

A Yeah. Yeah. Right. She did.

Q Okay. There is, on page 34, a section called "Feigned medical presentations." Do you see that?

A Yes.

Q The first line in that section, states, and I quote, "Practitioners should be concerned that illness behaviors such as resignation and accommodation produce poor motivation that may be mistaken for feigning." Correct?

A Yes.

Q What does that mean?

A That they've -- they've just kind of given up and -- and they may perform poorly because of that, instead of concluding that they're malingering and they just kind of didn't try.

Q Right. So an injured party's kind of just given up on themselves and that produces the same sort of presentation as someone that may be feigning, correct?

A Right.

Q We've talked about the MMPI-2-RF before, correct?

A Right.

Q And you dedicated a rather lengthy paragraph in your report to the findings of that test pertaining to Ms. Dillon, correct?

A Yes.

Q In this paragraph, you wrote, and I quote, "The MMPI-2-RF, infrequent Somatic Responses attempt to rely on the rare-symptom strategy, but its items often occur up to 25% in medical patients presenting genuinely." Did I read that correctly?

A Yes.

Q So up to 25 percent of the time, the MMPI shows that a patient is feigning symptoms even though the patient actually has those symptoms, correct?

A On that particular scale of those particular symptoms, yes.

Q Okay. So on that particular scale, on those particular symptoms, the test is wrong one in four times, correct?

A In certain populations, yeah.

Q Okay. And you even wrote that in that sentence that it attempts to rely on rare symptom strategy, correct?

A Yeah. I don't believe I wrote this paragraph, but yes, it's there.

Q Okay. And we discussed before that the MMPI is actually more for feigned mental disorders than feigned cognitive impairment, correct?

A There are more scales devoted to that, but the

cognitive ones are there as well.

Q Okay. And you actually wrote, "At best, the MMPI might serve as an initial screen requiring full evaluation." Correct?

A Is that in the same paragraph?

Q Well, yeah, last time -- last sentence.

A Oh, for medical presentations? Yeah, for -- yeah. I -- I would agree with medical presentations.

Q Okay. But in your report, you rely pretty strongly on it in Ms. Dillon's case, correct?

A Yes. Because she's presenting with mental and cognitive complaints too. Yeah.

Q You dedicate a whole section here to civil cases, correct?

A Yes.

Q And here you write about a comprehensive review from Young and a study by Ruff that were conducted in the mid-2010s that suggest the rate of malingering in civil cases may be as low as 15 percent, correct?

A That's correct.

Q And that number is even lower when you consider the gradient of definite malingering, correct?

A That's right.

Q When disentangled, the Ruff study actually

found that the rate was only 4.7 percent for probable malingering, correct?

A That's right.

Q So you think Ms. Dillon falls under the 4.7 percent of people in civil cases that are probably malingering?

A I do. And there's -- there's things that can be said about those studies. There's many, many more studies suggesting that the base rate's higher than that, but I thought these -- these studies are important because they were well-crafted. I -- the jury's still out though when it comes to -- to -- coming up with a precise base rate number.

Q Well, the truth is, because you've written on this, there is no scientifically established base rate when it comes to malingering, correct?

A That's -- that's right. There's -- there's no gold standard.

Q And you actually wrote in another chapter in this book that most base rates estimates of malingering are very likely to be substantial overestimates, correct?

A Yes.

Q Okay. You'd agree with me that as the base rate of malingering decreases, it increases the

percentage that you will get false positives on classifying someone as a malingerer, correct?

A That's right.

Q Okay. Let's take a look at some of your conclusions, your takeaways in this. Your first takeaway, and I quote, "To avoid malingering bias, practitioners should evaluate evidence of feigning and genuine responding fairly and integrate both into their report." Did I read that correct?

A Yes.

Q Okay. And after everything we've been through today, do you think you've met that goal in your evaluation and reporting of Ms. Dillon?

A Yes.

Q Okay. Where in your report do you think you fairly incorporated that Ms. Dillon may be genuinely reporting?

A All of her cognitive performances and her self-report in the interview.

A But nowhere in your conclusions, correct?

A No. There -- there as well. That's -- yeah. The summary takes into account those other sources. Sorry.

Q Okay. Your second takeaway is that, "Motivation for malingering must be investigated, not

facilely assumed from the circumstance." Did I read that correctly?

A Yes.

Q Meaning that you can't just go into something assuming someone is lying, correct?

A That's correct. You can't do that.

Q Okay. And in fact, protracted litigation like we're involved in right now can actually cause results on neuropsychological testing that appears to be feigning, correct?

A Yeah. And that appears to be a neurocognitive disorder too.

Q Sure. But another explanation outside of the neurocognitive disorder is just that being involved in protracted litigation causes results similar to feigning, correct?

A Yes. Because at least some of those times it is.

Q Okay. You wrote another book chapter called Malingered Traumatic Brain Injury, correct?

A Yes.

Q Earlier we talked about the difference between feigned mental disorders versus feigned cognitive impairment, and you agreed that there is a difference, correct?

A Yes.

Q And in that publication, Evaluation of Malingering and Related Response Styles, you provide a table of tests which you assert can be used when determining if there is feigned cognitive impairment. Do you remember that?

A I don't off the top of my head. Sorry.

Q All right. When did you write that article?

A I don't recall.

Q This is not a good picture, but this is Exhibit 6. I have it as a picture, which you can see better. Can you see that?

A I can't see what's written there, but I see that there is a table there.

Q All right. I want to -- I want to focus your attention to the measure column, which lists out different tests, correct?

A Is there a way you can enlarge it?

Q Yeah. Do you see it?

A No. I'm sorry. Nothing happened.

Q This isn't making it bigger at all?

A Let me see. Hold on one second. Okay. Well, maybe one more time. Can you increase it one?

Q Yeah. And I'll go down the list so that you've seen them all. It starts with "Rey 15," you see

that?

A Yes.

Q Okay. And then I'll go down. Tell me when you want me to go down further in the list.

A Okay. I can see down to "TOMM." Oh, sorry. The -- the second listing of "TOMM" is what I can see on this one table.

Q Yeah. That's all I want you to look at.

A Oh, okay. Okay.

Q Is that column, so can you see down to "WMS-R-S"?

A WM -- yes.

Q Okay. I'm going to keep going down. I just want to make sure you've seen all of these. Tell me when you want me to go down again.

A Okay. Go ahead. Okay. It's the same -- same screen.

Q Down to "TOMM"?

A Yes.

Q Okay. Did you perform any of those tests on Ms. Dillon?

A Yes.

Q Which ones?

A The RDS and the WMS.

Q Okay. And how did she do on them?

A Fine.

Q Okay. So from the -- your publication with the list of tests that you suggest to practitioners to utilize when looking for feigned cognitive impairment, the two that you utilize, Ms. Dillon passed, correct?

A Yes.

Q Okay. But you're still opining that she's feigning cognitive impairment, correct?

A Yes. Because of other evidence that she has.

Q Okay. And you have an article called "Malingered Traumatic Brain Injury" that you've updated over the years, correct?

A Yes.

Q And I've pulled up what is marked as Exhibit 7. This is that article, correct?

A Yes.

Q Okay. Let me see if I can find it. Somewhere in here, you have a section on prevalence of malingering. Oh, found it. Right there. The bottom of this page, you have a section on the "prevalence of malingering," correct?

A Yes.

Q Okay. And we talked about this before, but in this last paragraph in the section, you essentially state that, "the true prevalence of malingerers is

unknown and hard to calculate," correct?

A Well, the precise one. Yes, that's true.

Q I mean, you state, "The inability to know someone else's true motivations lies at the heart of the problem of malingering detection." Correct?

A Correct.

Q Okay. You also write, "Accurate classification of malingering is further compromised by the multiple conditions that can resemble malingering, such as factitious disorder, conversion disorder, PTSD, depression, and psychosocial factors involving exaggeration." Did I read that correctly?

A Yes. Correct.

Q Okay. And so in your own words, malingering or feigning can resemble other disorders, correct?

A Oh, yes.

Q And that includes anxiety, correct?

A Right. Yeah. That's why we have to have these detection strategies that can differentiate the two.

Q And it -- and it includes depression, correct?

A Yes.

Q And Ms. -- and you agree Ms. Dillon has anxiety and depression, correct?

A Yes.

Q So any of those disorders which Ms. Dillon has been diagnosed with could explain a presentation that may be similar to feigning or malingering, correct?

MR. KING: Object to form.

THE WITNESS: Not in -- in this case. No. My opinion is that the scales that are validated to do that very thing, they're -- they're validated to differentiate anxiety and depression from feigned anxiety and depression. Those -- those scales are the ones that are elevated.

BY MR. LADUCA:

Q All right. Well, it's such a problem that you acknowledge, and I quote, "Given these problems, some researchers have argued that psychologists should not classify malingering at all, but just report the validity or lack thereof of test results." Did I read that correctly?

A Yeah, that's correct. Yeah, that's -- there are people who suggest that. I'm not -- I'm not one of those, but I -- I do understand their argument.

Q Right. And their argument is just reporting the validity of test results is the safest thing to do given the cloudiness and also the ramifications of classifying someone as a malingerer, correct?

A That's absolutely right. You have to take it

very, very seriously and do it carefully.

Q Okay. But as you said, unlike psychologists that want to take that safe route, you don't just report the validity of test results, correct?

A Not usually. I -- I think we're positioned to do more than that. But in some cases, I would report just on the validity of the test result.

Q In this article, you also talk about mTBI, correct?

A Yes.

Q And mTBI is, how you say in the medical parlance, mild traumatic brain injury, right?

A Yes.

Q And you state in this paragraph that under definitions, that, "In contrast to severe or even moderate TBI, mild TBI cannot be found on neuroimaging." Correct?

A That's right. We would -- we would call it something else usually if there was evidence on imaging.

Q Right. So imaging is generally normal when a plaintiff has or a patient has a mild TBI, correct?

A Correct.

Q Okay. You also describe the symptoms of a mild TBI in this article, correct?

A Yeah.

Q Okay. And you states, and I'm looking at this paragraph here, the "Acute symptoms of mTBI include, less than 24 hour post-injury, include confusion, disorientation, dizziness, gait abnormality, visual disturbance," also known as the diplopia, or that would be an example, "and headache." Did I read that correctly?

A Yes.

Q You write that, "Many of these symptoms can persist into the post-acute phase," which is 7- to 10 days post-injury, "but can also emerge post-acutely, after an asymptomatic period/" Correct?

A That's right.

Q All right. In terms of the acute period, you agree that Ms. Dillon reported every single one of the symptoms you list within the post-acute phase after the collision, correct?

A Yes.

Q And you agree that even if she did not report the symptoms post-acutely, which she did, that would not rule out a mild TBI because symptoms can emerge later even after an asymptomatic period, correct?

A No. It wouldn't rule it out. No.

Q Okay. So there can be a period of no symptoms and then symptoms appear later, correct?

A That's usually a short period, a couple weeks tops.

Q Okay. And then you write, the "Symptoms that emerge after the acute phase tend to be more cognitive in nature, such as amnesia, attention deficits, and slow cognition processing speed, although any of the symptoms can occur during either phase." Did I read that correct?

A Yes.

Q And Doctor, again, those are the exact cognition symptoms as reflected in her medical records which Ms. Dillon reported in the acute period, correct?

A That's right.

Q Okay. Finally in this paragraph, you write, "Pain is often a primary complaint both early and later in the course of recovery, and psychological disturbances are not uncommon, especially later in the course of recovery." Did I read that correctly?

A That's correct, yes.

Q Ms. Dillon has continually reported pain since the collision, correct?

A I believe that's correct.

Q And we agree that she has ongoing psychological disturbances in the form of anxiety and depression, correct?

A Yes.

Q Okay. So by the words in your own article, we can agree that she has a mild TBI including the symptoms you'd expect to see later in the recovery from a mild TBI, correct?

A Well, no. I wouldn't say this suggests that those symptoms owe to mild TBI at this point.

Q Okay. But you do admit in your article at least that the symptoms, the psychological symptoms, anxiety and depression are things that you see later in the recovery period and that's normal, correct?

A Yeah, not unusual.

Q Okay. Sorry. Just trying to speed it along here.

You wrote down here in the masquerading symptoms and the differential diagnosis of mTBI section, "For example, depressive disorders occur in approximately 75% of moderate to severe cases of TBI, but also occur in 14-35% of patients with mild TBI." Correct?

A Correct.

Q All right. So up to 35 percent of patients have depression after suffering a mild TBI, correct?

A Yeah. What that doesn't take into account though is whether or not there are incentives and what's causing the depression. It -- it's -- they're just

correlational studies. It doesn't mean they're from the TBI.

Q Depression is associated with cognitive dysfunction, correct?

A It can be.

Q No method exists to determine whether symptoms represent depressive disorder or a neuropathological component of the mild TBI, correct?

A Whether the depression is due to pathophysiological changes associated with mild TBI? Is that --

Q Right. No method exists to determine whether depressive symptoms represent a depressive disorder or a neuropathological component of the mild TBI, correct?

A Well, I mean, there's a lot of research showing that it's unlikely to at least to be the -- to be the concussion alone. It's usually a combination of having had the symptoms before -- and if they didn't have the -- the symptoms before, it -- it occurs in -- in moderate and severe cases as well.

Q Doctor, did you write, "No accurate methods exist to determine whether symptoms represent a depressive disorder or a neuropathological component of the mild TBI"?

A Yes. And I hope that -- I don't think that

that's in -- in contrary to what I just said.

Q Okay. Anxiety can also diminish cognitive efficiency in its own right, correct?

A Yes.

Q And anxiety is a highly comorbid with depression, correct?

A Yes.

Q Meaning when one exists, the other usually exists, correct?

A Correct.

Q PTSD can also diminish cognitive functioning, correct?

A Yes.

Q And it's very difficult to differentiate between the symptoms of PTSD and the symptoms associated with a genuine mild TBI, correct?

A Yes.

Q And recent research has shown that PTSD is actually pretty common after an individual suffers a mild TBI, correct?

A Yeah. Yeah.

Q Okay. And you wrote that in this article, correct?

A Yes, I think so.

Q Okay. Pain can also produce symptoms and

cognitive deficits similar to those of mild TBI, correct?

A Yes.

Q But neuropsychological evaluations are not designed to detect pain, correct?

A Not directly. They often do, but they're not designed to necessarily.

Q Okay. The comorbidity of mild TBI and clinical conditions of depression, PTSD, and pain has not been systemically evaluated, correct?

A That's right.

Q So there's no science which you can point to which can differentiate the origin of a patient's symptoms between those conditions, correct?

A There's science that can help answer it, but there's nothing that can do it definitively.

Q Okay. We go to page 132. You wrote here that, "It is not difficult to imagine how disastrous the consequences would be for a genuine patient who is incorrectly classified as a malingerer." Did I read that correctly?

A Yes.

Q Do you still agree with that statement?

A Oh, yes.

Q On page 135, you talk about the MMPI. You

dedicated a whole section there to the MMPI-2 and the MMPI-2-RF, correct?

A Yes.

Q Okay. And in your opening paragraph, you wrote, "It's critical to note that the MMPI-2 validity scales were not designed to evaluate the genuineness of examinees' cognitive complaints." Did I read that correctly?

A Yes. And that doesn't take into account the FBS or RBS scales.

Q Okay. But that remains true with the MMPI-2-RF, correct?

A No. I mean, those two scales that I just mentioned are now in the RF.

Q Okay. So that has been fixed with the revised version?

A Yes.

Q Okay. On page 140, you cite multiple studies, and hopefully you'll just remember this so we don't have to look at them. For the proposition that litigation and compensation-seeking status are not good predictors for neuropsychological performance or malingering, correct?

A There's -- there's conflicting data on that. I just looked at a study actually that did show on a

meta-analysis that litigation had unique independent predictive --

Q This may be a silly question given what we've established, but during your examination of Ms. Dillon, did you find her to be believable?

A In part, yes.

Q And yet you still believe she's exaggerating symptoms, right?

A Yes.

Q Do you think that's a judgmental evaluation?

A No. It's -- it's based on clinical strategies, techniques, and testing data.

Q Okay. Nowhere in your report, and you have it in front of you, do you state that any of your opinions are held to a reasonable degree of professional or medical probability, correct?

A Oh, I didn't realize that. Yes, that's correct.

Q Okay. Do you want to -- do you know when the trial of this matter is?

A I don't.

Q Okay. Do you plan to testify live at that trial?

A If needed.

Q All right. And the cost associated with that

would be the $400 an hour?

A Yes.

MR. LADUCA: Give me five minutes, but I think that might be all I have, Doctor.

THE WITNESS: Okay. Thank you.

THE REPORTER: Without objection, we're now going off the record. The time is 3:57 p.m., Eastern Standard Time.

(Off the record.)

THE REPORTER: Without objection, we are back on the record. The time is 3:59 p.m., Eastern Standard Time.

MR. LADUCA: All right, doctor. Just about an hour or so to go more. I'm just kidding. I'm done with you. I'm done.

THE WITNESS: I guess that was a -- a good -- a good ending.

EXAMINATION

BY MR. KING:

Q Doctor, listen, I just have one question because I think this question was asked a couple of different times, and I think you answered it and I think it was clear. But one of the answers you gave to one of the final questions posted by Plaintiff's counsel was confusing to me.

Are the opinions that you expressed in your report expressed by you to a reasonable degree of neuropsychological probability?

MR. LADUCA: Objection.

THE WITNESS: Yes. Oh.

MR. LADUCA: That's fine. You can -- I was -- I'm just noting my objection.

BY MR. KING:

Q Did you answer?

A Yes.

MR. KING: All right. That's it.

MR. LADUCA: That's it.

THE REPORTER: Prior to going off the record, Attorney LaDuca, I would just like to confirm, will you be purchasing the original transcript?

MR. LADUCA: Not at this time. No.

THE REPORTER: And Attorney Phillip -- or Attorney King, will you be purchasing a copy of the transcript?

MR. KING: Not at this time.

THE REPORTER: Okay. Thank you.

Without objection, we are now going off record. The time is 4:01 p.m., Eastern Standard Time.

MR. KING: Let me say one other thing before we go off the record. I thought you may bring it

up with the witness.

But, Doctor, you have a right -- if the transcript is ordered, to read and sign the transcript. It's entirely up to you. Just to make sure your -- the questions and answers were transcribed correctly. So you just let us know. If it is ordered, would you like to read and sign?

THE WITNESS: Yes.

THE REPORTER: Noted. Thank you.

Now, without objection, we are now going off the record. The time is 4:01 p.m., Eastern Standard Time.

(Proceedings concluded at 2:58 p.m.)

(Read and Sign requested / Read and Sign waived.)

* * * * *

CERTIFICATE OF NOTARY PUBLIC

State of Ohio)
County of kings)

I hereby certify that on the 2nd day of january, 2021, before me, a RON notary public for the State of Ohio, MARTHA ROSARIO remotely appeared via videoconference, and prior to testifying, swore an oath, to tell the truth.

DATED this 2nd day of january, 2021.

_____

RON Notary Public
State of Ohio
Commission No.: 39347
Commission Expiration: 12/27

CERTIFICATE OF REPORTER

I, Kimberly Jones, hereby certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That the proceedings were recorded by me and thereafter formatted into a full, true, and correct transcript of same;

I further certify that I am neither counsel for nor related to any parties to said action, nor in any way interested in the outcome thereof.

DATED, this 2nd day of january, 2021.

_____

Kimberly Jones

Court Reporter

A C K N O W L E D G E M E N T

I do hereby certify that having been first duly sworn to testify to the truth, I gave the above testimony on Wednesday, February 21, 2024.

I further certify that the foregoing transcript is a true and correct transcript of the testimony given by me at the time and placed specified.

_____

MARTHA ROSARIO

Sworn to before me this ___ day of _____, 20__

_____

Notary Public

E R R A T A S H E E T

Deponent: MARTHA ROSARIO
Deposition Date: Wednesday, February 21, 2024

PAGE	LINE	CHANGE FROM/TO	REASON FOR CHANGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Under penalties of perjury, I declare that I have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____ _____

MARTHA ROSARIO Date

Sworn to before me this ___ day of _____, 20__

_____

Notary Public