1 IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
2 EASTERN DIVISION

3 WENDY B. DOLIN, Individually)
and as Independent Executor)
4 of the Estate of STEWART)
DOLIN, Deceased,)
5)
Plaintiff,)
6)
-vs-) Case No. 12 CV 6403
7)
SMITHKLINE BEECHAM)
8 CORPORATION, d/b/a)
GLAXOSMITHKLINE, a)
9 Pennsylvania corporation,) Chicago, Illinois
) April 11, 2017
10 Defendant.) 1:15 p.m.

11 VOLUME 17-B
TRANSCRIPT OF PROCEEDINGS - Trial
12 BEFORE THE HONORABLE WILLIAM T. HART, and a Jury

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1 (Proceedings heard in open court, jury not present:)
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6 (Jury enters courtroom.)
7 THE COURT: All right. Thank you very much, ladies
8 and gentlemen. Please be seated. We will resume.
9 Is your witness here?
10 MR. BAYMAN: Yes, sir, your Honor.
11 THE COURT: Step up here, please. Is there a book on
12 the stand that belongs there?
13 MS. HENNINGER: Yes, it belongs there.
14 THE COURT: All right. Please raise your right hand,
15 sir.
16 (Witness sworn.)
17 THE WITNESS: I do.
18 THE COURT: You may take the witness stand.
19 You may proceed, sir.
20 MR. BAYMAN: Thank you, your Honor.
21 ANTHONY ROTHSCHILD, DEFENDANT'S WITNESS, DULY SWORN.
22 DIRECT EXAMINATION
23 BY MR. BAYMAN:
24 Q. Could you please tell the jury your name.
25 A. Anthony Rothschild.

1 MR. BAYMAN: Your Honor, I'd like to proffer
2 Dr. Rothschild's credentials to the jury.
3 THE COURT: Yes.
4 MR. BAYMAN: Dr. Anthony Rothschild attended
5 Princeton University and then went on to get his medical
6 degree from the University of Pennsylvania Medical School in
7 1979. After graduating from medical school, Dr. Rothschild
8 completed a four-year residency in psychiatry at McLean
9 Hospital in Belmont, Massachusetts, which is affiliated with
10 the Harvard Medical School. During his residency,
11 Dr. Rothschild was a clinical fellow in psychiatry at Harvard
12 Medical School.
13 He is licensed to practice medicine in the
14 Commonwealth of Massachusetts. Dr. Rothschild is
15 board-certified as a specialist in psychiatry by the American
16 Board of Neurology and Psychiatry.
17 Dr. Rothschild has published 120 articles in
18 peer-reviewed medical and scientific journals and numerous
19 abstracts, letters, commentaries, books, and book chapters
20 addressing various issues in psychiatry and
21 psychopharmacology.
22 Dr. Rothschild is currently employed at the
23 University of Massachusetts Medical School and its clinical
24 partner, the University of Massachusetts Memorial Healthcare,
25 as professor of psychiatry and director of the University of

1 Massachusetts depression center. Dr. Rothschild has been
2 employed there for over 20 years.
3 BY MR. BAYMAN:
4 Q. Dr. Rothschild, I just mentioned to the jury that you're
5 employed at the University of Massachusetts Medical School.
6 What do you do there?
7 A. Well, I'm a professor of psychiatry, and I do a lot of
8 different things. I treat patients, like any other
9 psychiatrist. I do research, and I've done that my whole
10 career, both of those things my whole career, research, what's
11 called clinical research to study new potential treatments for
12 depression, investigator on what are called clinical trials
13 where we study the medication versus a placebo. I'm currently
14 doing that now.
15 I also teach medical students at the UMass Medical
16 School. I also teach residents in training in psychiatry.
17 These are people who have done medical school, but now they're
18 specializing in psychiatry. And the teaching is both
19 lectures, formal lectures as well as hands-on with the patient
20 type teaching.
21 Q. Prior to teaching at the University of Massachusetts, have
22 you held any other teaching positions?
23 A. Yes.
24 Q. Tell the jury about that briefly.
25 A. Well, I went to UMass Medical School in 1996 and have been

1 there a little over 20 years. Before that, I was at Harvard,
2 at Harvard Medical School, and I rose to the rank of associate
3 professor of psychiatry, and so I did the same thing basically
4 when I was at Harvard that I just said that I do at UMass.
5 Q. As part of your teaching responsibilities, have you given
6 lectures related to the use of what's called SSRIs?
7 A. Yes, many times.
8 Q. Have you given lectures about FDA labeling for
9 antidepressant medications?
10 A. Yes. Well, when you're talking about medications, you
11 discuss the label, too.
12 Q. Have you held any leadership positions?
13 A. Yes, I have. I won't name them all, but when I was at
14 Harvard Medical School, I -- for many years, I ran the
15 depression treatment unit where people who had made suicide
16 attempts were admitted for inpatient treatment. Eventually, I
17 was moved upstairs, and I was the clinical director of what
18 was called the mood, anxiety, and trauma disorders program, so
19 several inpatient units and outpatient facilities.
20 At UMass, I've been vice chair for research, director
21 of clinical research. Right now I'm head of the UMass
22 depression center.
23 So, those are sort of the highlights.
24 Q. Have you received any honors in your practice or for your
25 research or teaching?

1 A. I have. I'll just name a few. I'm in *Best Doctors*. So,
2 that's a book published where you're elected to by your fellow
3 doctors, and I've been in that since 2001.
4 I received the Massachusetts Psychiatric Society
5 award for outstanding researcher of the year. And I've
6 received many teaching awards for teaching medical students
7 and residents.
8 Q. Now, I read -- I mentioned to the jury that you authored
9 journal articles. Have you held any leadership positions or
10 other positions with scientific journals?
11 A. Yes. I'm on the -- currently on the editorial board of a
12 couple of journals, *Comprehensive Psychiatry*, *Journal of*
13 *Clinical Psychiatry*, *Depression and Anxiety*. And then I'm a
14 reviewer for something like 35 journals, including the
15 *New England Journal of Medicine*, the *Archives of General*
16 *Psychiatry*, *JAMA Psychiatry*.
17 Q. Explain to the jury what you do as a reviewer.
18 A. So, for these journals, when somebody does a study and
19 writes a paper and wants it published, they submit it to the
20 journal; and the journal sends it out to reviewers, who are --
21 it's usually a blinded process. The authors don't know who
22 the reviewers are and vice-versa.
23 And you critique the paper. I mean, you want to look
24 at whether the methods were sound in the paper, what the
25 results were, whether the conclusions they draw from the

1 results are -- fit -- they're not over-interpreting the data.
2 And then you make a recommendation to the editor, either
3 accept it or should authorship modify it or reject it.
4 Q. Are you a member of any professional organizations?
5 A. Yes.
6 Q. Tell the jury about that, if you would.
7 A. Well, I'll just name a few. I'm a distinguished life
8 fellow of the American Psychiatric Association. I'm a
9 member -- actually a fellow of the American College of
10 Neuropsychopharmacology, something called the ACNP. Now, that
11 is something you can't just join. You have to be elected to
12 that, and it's become -- it's very competitive. So, that's
13 based on your accomplishments in the field.
14 I'm also a fellow in the international version of
15 that, which is the Collegium Internationale
16 Neuro-Psychopharmacologicum. I'm a member of the American
17 Psychopathological Association, and a few others, but those
18 are the main ones.
19 Q. Have you served as an examiner in psychiatry for the
20 American Board in Psychiatry and Neurology?
21 A. I have.
22 Q. Tell the jury what that entails.
23 A. Well, when psychiatrists want to become board-certified,
24 they have to pass a written test, and they had to pass what's
25 called the oral version. So, people who want to be

1 board-certified would interview a patient in front of two
2 examiners. And I was one of those examiners for many, many,
3 many years. And we either pass-fail the candidate -- I mean,
4 the thing we used to use was: Would you refer a family member
5 to this doctor? And if the answer was no, they usually
6 failed.
7 But, you know, it was sort of -- that's what an
8 examiner did.
9 Q. Now, in addition to your research and your teaching, do
10 you actually treat patients?
11 A. Yes. I have a practice at UMass Memorial Hospital, mainly
12 outpatient, occasional inpatient; but I have my own patients
13 who are not involved in research studies.
14 Q. Do you have personal experience diagnosing and treating
15 patients with depression and anxiety?
16 A. Yes, I do.
17 Q. And about how many patients with depression and anxiety
18 have you treated in the course of your career?
19 A. Oh, my goodness. I've been doing this for more than
20 30 years. It's thousands. It's got to be over 10,000.
21 Q. Has a particular focus of your work, including your
22 research and your teaching, been on suicide?
23 A. Well, you know, I've specialized in treating depression
24 and anxiety, particularly severe forms, treatment-resistant --
25 people who have treatment-resistant illnesses, a form of

1 depression called psychotic depression.
2 And suicide is part and parcel of all of these
3 things. I mean, the risk of suicide in people suffering from
4 anxiety, for example, is 16 times what it is in the general
5 population, and similar in depression. So, I have worked with
6 a lot of suicidal patients.
7 And in my job when I was at MacLean Hospital, Harvard
8 Medical School, all of the patients who had made serious
9 suicide attempts came to my unit, and I had the opportunity to
10 talk with them. So, a lot of these people should have been
11 dead. It was just by some freak of nature that they survived.
12 But I've probably talked to hundreds of people who have made
13 very serious suicide attempts in the course of my career.
14 Q. So, have you actually interviewed people after they've
15 attempted suicide?
16 A. Oh, yes.
17 Q. Have you conducted what are called psychological
18 autopsies?
19 A. Yes.
20 Q. Explain to the jury what a psychological autopsy is.
21 A. So, this is after somebody -- it's usually after somebody
22 commits suicide. What you do is -- and I've been asked to do
23 this at UMass when we had a suicide, somebody -- a patient
24 somebody was seeing. You try and put together what the
25 reasons were the person committed suicide if you can.

1 THE COURT: Doctor, if you talk just a little slower,
2 the court reporter is trying to take everything down.
3 THE WITNESS: I'm sorry. Feel free to warn me.
4 THE COURT: We want to have a record.
5 BY MR. BAYMAN:
6 Q. Yeah.
7 A. You talk to the healthcare, the doctors and the nurses who
8 may have been involved in the patient's care; and you also
9 talk to family members, and if you have the ability to talk to
10 people they worked -- as many people as you can talk to to try
11 to put together, review the medical records, to figure out
12 what happened.
13 Q. And you would actually talk to loved ones about the
14 patient's behavior prior to committing the suicide?
15 A. Yes, I mean, as many people as you can.
16 Q. Does your experience including using medications to treat
17 patients suffering from anxiety and depression?
18 A. Yes, of course.
19 Q. And among the medications that you prescribe, does that
20 include paroxetine or Paxil or other SSRI antidepressants?
21 A. All of them, paroxetine and all the SSRIs.
22 Q. In the course of your career treating patients with Paxil
23 or paroxetine or other antidepressants, have you ever had a
24 patient become suicidal because of the treatment?
25 A. No.

1 Q. Are you being paid for your work in this case, Doctor?
2 A. Yes.
3 Q. What do you charge per hour of your time?
4 A. I charge $500 an hour.
5 Q. Do you charge the same rate no matter what you're doing on
6 the case?
7 A. Yes, same rate.
8 Q. How many hours have you spent on this case?
9 A. Well, it's a lot. I think it's around 289 the last time I
10 counted. There was a tremendous volume of deposition
11 testimony and records to review.
12 Q. What percentage of your time do you spend consulting with
13 lawyers such as myself in litigation?
14 A. Well, I'd say it's about 5 to 10 percent of my time. I
15 mean, that's based on an 80-hour workweek. I mean, I have a
16 regular job. I do this on nights and weekends. Except if I
17 have to come like I'm doing now to Chicago, it's all kind of
18 nights and weekends. So, it's about 5 to 10 percent of
19 80 hours.
20 Q. Do you consider yourself a professional witness?
21 A. No. I have a regular job. I have a regular job as a
22 professor at UMass Medical School.
23 Q. I want to turn now to this case.
24 A. Sure.
25 Q. What were you asked to consider and review in this case,

1 Doctor?
2 A. I was asked to review the medical records of Mr. Dolin,
3 all the deposition testimony related from his healthcare
4 providers, from family, people at work, other people. There
5 was a large -- as I mentioned, there was a large volume of
6 records related to Mr. Dolin.
7 I reviewed the Food and Drug Administration's
8 analysis of the double-blind placebo-controlled clinical
9 trials with paroxetine. I also reviewed GlaxoSmithKline's
10 analysis.
11 And so, it was a combination of all of those things.
12 Q. What was the kind of overarching question that you were
13 asked to address?
14 A. The overarching question is: Did paroxetine play any role
15 in Mr. Dolin's suicide? Or put another way, why did Mr. Dolin
16 commit suicide?
17 Q. And have you assisted us in preparing a graphic with a
18 summary of your opinions?
19 A. I did.
20 (Discussion between counsel, not within hearing.)
21 MR. RAPOPORT: Your Honor, if I could, I've got --
22 what is this, 19 different pages of things I've never seen
23 before. I'd like a moment to look at it.
24 MR. BAYMAN: Sure.
25 MR. RAPOPORT: Is there any particular page you're

1 starting with?
2 MR. BAYMAN: Yeah, the first page behind Tab 20,
3 summary of opinions, just a slide. It's demonstrative.
4 MR. RAPOPORT: We object to the substance but not the
5 procedure. No objection to that, your Honor.
6 THE COURT: All right.
7 MR. BAYMAN: Permission to publish that, your Honor?
8 THE COURT: You may publish.
9 BY MR. BAYMAN:
10 Q. Did you reach an opinion as to whether paroxetine caused
11 or contributed to Mr. Dolin's suicide?
12 A. I did.
13 Q. And what is that opinion?
14 A. That paroxetine did not cause or contribute to Mr. Dolin's
15 suicide.
16 Q. And do you hold that opinion to a reasonable degree of
17 scientific and medical certainty?
18 A. I do.
19 Q. What other opinions do you hold in this case?
20 A. Well, related to that is that it's my opinion that the
21 reliable scientific evidence doesn't support the conclusion
22 that paroxetine causes suicide or that akathisia causes
23 suicide.
24 And then specifically related to Mr. Dolin, it's my
25 opinion that Mr. Dolin did not have akathisia, that Mr. Dolin

1 suffered from severe paralyzing anxiety, possibly also major
2 depressive disorder. He had longstanding fears and feelings
3 of inferiority and inadequacy related to his job.
4 And then in 2010, in the months preceding his
5 suicide, he had a lot of very severe stresses at work, harsh
6 criticism by his colleagues. He had a decrease in his
7 compensation which he himself described as a seismic shock.
8 He was no longer the sole leader of the practice group. He
9 had serious issues with two very important clients.
10 And what I saw in his therapist's notes is that there
11 was this thing called the fear loop, which is described back
12 in 2007 but reappeared in 2010.
13 There were family stresses, including feelings of
14 inadequate financial arrangements he felt that he had made for
15 his family. And he had uncoordinated mental health treatment
16 from his healthcare providers.
17 Q. And do you hold these other opinions to a reasonable
18 degree of medical and scientific certainty?
19 A. I do.
20 Q. Do you believe Mr. Dolin acted under an irresistible
21 impulse to commit suicide?
22 A. No.
23 Q. Why not?
24 A. Well, I think as we'll talk about, Mr. Dolin had been
25 deteriorating for several months; and as I think we'll also

1 talk about, the day he committed suicide, he -- he had to plan
2 to walk several blocks, discard his cellphone and so forth, so
3 there was no irresistible impulse.
4 We'll talk about this, I think, later, but if he had
5 an impulse he couldn't control, he would have had many
6 opportunities to throw himself in front of a car or a truck on
7 the way to the station. There was a closer station. But I
8 think we'll get into that later.
9 Let's put it this way. There's no evidence of an
10 irresistible impulse, and frankly, there's no evidence in the
11 scientific and medical literature of such a thing.
12 Q. I'd like you to turn in your notebook to Tab 1.
13 MR. BAYMAN: This is Plaintiff's Exhibit 88, your
14 Honor. It's been previously published to the jury, and I'd
15 ask for permission to publish it now.
16 THE COURT: You may proceed.
17 BY MR. BAYMAN:
18 Q. Dr. Rothschild, the jury has heard from both of -- two of
19 the plaintiff's experts, Dr. Healy and Dr. Glenmullen, about
20 an article that you co-authored back in 1991 about a potential
21 relationship between Prozac, akathisia, and suicidality. Do
22 you recall that article?
23 A. Yes.
24 Q. And is that the article we've put on the screen?
25 A. Yes.

1 Q. It's entitled, "Reexposure to Fluoxetine After Serious
2 Suicide Attempts By Three Patients: The Role of Akathisia"?
3 A. That's correct.
4 Q. We're going to talk about akathisia, but can you briefly
5 describe to the jury what akathisia means.
6 A. Well, it basically means an inability to sit still.
7 Someone who has akathisia is constantly moving, pacing.
8 I mean, if I have someone in my office with akathisia and I'll
9 say, "Mr. Jones, please sit down," they'll sit down, but
10 within 10 seconds, they'll be up pacing around. I mean, it's
11 a really obvious thing. You don't really need to be a doctor
12 to notice that something's wrong. It's just the patient is
13 constantly moving.
14 I wouldn't be able to sit here if I had akathisia. I
15 would have to get up and move around constantly. You'd see
16 it -- you know, within two minutes, you could see it.
17 Q. When did you publish this article?
18 A. In 1991.
19 Q. Who was the senior author on the paper?
20 A. I was.
21 Q. And who was -- the jury's heard from Dr. Healy about Carol
22 Locke. Who was Carol Locke?
23 A. Carol Locke was my resident in training. She was a
24 psychiatrist in training. She was a resident. And she was
25 assigned to work with me on the depression and treatment unit,

1 so we used to see patients together as part of her learning.
2 And these three patients that are described in this
3 paper, we both saw, so I thought it would be nice to add her
4 as a co-author. It was her first publication.
5 Q. So, if Dr. Healy described her as the principal author,
6 would that be correct?
7 A. No. No, it would not.
8 Q. How many patients did this article involve?
9 A. Three people.
10 Q. And they -- were they taking Prozac?
11 A. They were.
12 Q. Was your article a study?
13 A. No.
14 Q. Explain that.
15 A. So, these are what are called case reports; but basically
16 what it was, I was doing my job as a psychiatrist in charge of
17 depression treatment unit, and I had these experiences with
18 these three patients, in the course of doing my job, in the
19 course of treating them. There's no -- there was no study
20 design or anything like that.
21 But I thought it was worthwhile to report my
22 observations because at the time, there was -- as I say in the
23 first sentence, there was a considerable controversy in the
24 field. Somebody -- another doctor, actually, at the hospital
25 I worked at, Dr. Teischer, had raised this question about

1 whether Prozac might cause suicide. And he was -- he made a
2 lot of media appearances; and a lot of psychiatrists were
3 wondering what was going on, and the patients were getting
4 worried and asking questions.
5 And when I had these observations about the
6 possibility of akathisia playing a role, I thought it was
7 worth raising the question as to whether this was just simply
8 maybe akathisia. Because akathisia, when you recognize it, is
9 easy to treat. It's actually two of the three people, you
10 just give another medication, a low dose of a medication
11 called propanolol, which is actually a blood pressure
12 medication, but at low dosages, it can just completely wipe
13 out akathisia. And I did that here, and it worked.
14 And so I was proposing a question as to whether this
15 controversy might be due to akathisia. But it was basically
16 raising a question. That's what case -- that's the only thing
17 you can do from case reports.
18 Q. In your opinion as a medical doctor, can case reports be
19 used to establish causation?
20 A. No.
21 Q. Why not?
22 A. Well, to -- to establish causation, first of all, you have
23 to do a double-blind, randomized, controlled clinical trial.
24 That is the gold standard, and that's the first thing you
25 would do to see if there is a difference between the drug, say

1 in this case Prozac, and people who get a sugar pill.
2 And say you're interested in akathisia, you would
3 look at -- so, the patients don't know whether they're getting
4 the Prozac or the placebo. That's why blinding is very
5 important, and neither do the doctors know. So, it keeps it
6 objective. And that's what you would need to do to answer
7 that question.
8 And then actually, it was done a couple of years
9 later.
10 Q. We'll talk about that in a minute. Have you taken the
11 position that case reports are not a good method for
12 establishing causation?
13 A. I have, many, many, many times.
14 Q. In your article anywhere do you say that the three Prozac
15 case reports established causation?
16 A. I did not.
17 Q. If someone used your article to say that Prozac caused
18 patients to develop akathisia, which then caused them to
19 become suicidal, what would you say?
20 A. You cannot use case reports to make any kind of argument
21 about causation.
22 Q. Now, even if one were to reach a conclusion about Prozac
23 from your article, would that apply to Paxil or paroxetine?
24 MR. RAPOPORT: Objection, your Honor. Leading.
25 You've been tolerant of it, but we should hear from the

1 witness, not Mr. Bayman.
2 MR. BAYMAN: It was an open-ended question.
3 THE COURT: You may answer.
4 BY THE WITNESS:
5 A. If you were interested in studying paroxetine, you would
6 study paroxetine. As a matter of fact, Prozac was the first
7 SSRI on the market. The people who made the other ones
8 couldn't just say, "Oh, that drug is like ours, and FDA please
9 approve it." That would never happen. You would have to do
10 the study of the drug in question.
11 BY MR. BAYMAN:
12 Q. And you mentioned there came a point in time that Lilly
13 actually looked at the clinical trials to answer the
14 hypothesis that you posed in this article?
15 A. Yes. And when I wrote this, I mean, I was hoping by
16 raising the question that the medical community would look at
17 it. And the other reason, by the way, you know, I think I say
18 this in the article, I was trying to alert doctors to be on
19 the lookout if a patient has akathisia. Regardless of the
20 cause, it's something that should be treated.
21 But anyway, Lilly looked at it. They looked at their
22 database. They looked at the double-blind randomized
23 controlled trials, at this specific question, and they didn't
24 find any difference between Prozac and placebo.
25 So, the question was raised by me. I mean, I was one

1 of the first people in the world to raise this question. And
2 then the question was answered, and the answer was no.
3 Q. And did GSK do a similar analysis to see if Paxil or
4 paroxetine was causing akathisia, which in turn caused
5 suicidal thinking or behavior?
6 A. They did, and it was the same answer. Paroxetine,
7 double-blind studies of placebo-controlled studies of
8 paroxetine were also looked at, and the answer was no,
9 akathisia was playing no role in causing people to commit
10 suicide or even feel suicidal.
11 Q. Dr. Healy, I'd ask you to assume, has described your
12 article as challenge, de-challenge rechallenge. First of all,
13 what in your experience is a challenge, de-challenge,
14 rechallenge?
15 A. Well, challenge is when you give the medicine,
16 de-challenge is when you take it away, and rechallenge would
17 be when you give it back.
18 Q. And did your article involve a true de-challenge in the
19 sense that all the patients had their suicidal ideation go
20 away once the Prozac was stopped?
21 A. Well, in a sense, it was that. If you read the article,
22 that's what I did. But it wasn't a study -- if you do a study
23 in psychiatry, if you wanted to do a challenge, de-challenge
24 rechallenge, it has to be blind.
25 In other words, I remember this vividly, even though

1 it was 26 years ago, that when I was asking the patients to
2 retry the Prozac, they were really nervous about it. I was a
3 little nervous, too. I mean, I didn't know what was going to
4 happen. But they were on my inpatient unit. I told --
5 reassured them I was going to watch them. But they were
6 really nervous before I even did anything.
7 If you really wanted to do this, you would have to
8 have a blinded study so the patients wouldn't know when the
9 medicine is stopped or when the medicine is restarted. It
10 would just happen behind the scenes. And then you could
11 answer that question. Because in psychiatry, I guess
12 unfortunately, we don't have an x-ray. We don't have some
13 blood test that will tell us an answer.
14 So, you know -- and some of these feelings can be
15 subjective. And, you know, you can -- people get anxious.
16 I'm doing studies now, and the people get anxious when they're
17 trying a new drug. But they don't know whether they're
18 actually getting the new drug or not. Do you see what I'm
19 saying?
20 So, it would have to be blinded, because of
21 subjective -- this was not blinded. Everyone knew what was
22 happening. So, you can't make an interpretation from this
23 kind of a case report.
24 Q. And is it -- is blinding important because if the patient,
25 in your experience, believes that he or she is on a drug, that

1 it may be more likely for them to attribute a symptom to the
2 drug?
3 A. Correct. I mean, these people, even before I did this,
4 believed that the drug may have been playing some role, and so
5 they're a little bit biased in that regard. And, you know,
6 people can have unconscious biases, too. I mean, I as an
7 investigator, I mean, I have my biases. So, you would -- you
8 know, I'd want the patient to get better. I might be too
9 encouraging. So, that's why it's important to be blind so
10 that you can really analyze whether it's the effect of the
11 drug or not.
12 And let me just add, that was done. Okay? That was
13 done in the -- in the analysis of the Lilly -- the Prozac
14 database; and GSK did it with the paroxetine database, and the
15 answer is no, there's no relationship between akathisia and
16 suicide.
17 Q. Is the issue of whether paroxetine or Paxil or other SSRI
18 medications, whether they can cause suicide in adult patients
19 one that you followed in the course of your medical career?
20 A. Yes.
21 Q. And I'm not -- you mentioned what you've reviewed as part
22 of your work in this case. I'm not going to get into those
23 analyses. But have you reviewed in your review of the
24 analyses in this case -- do you have the opinion as to whether
25 Paxil or paroxetine can cause or induce suicide in adult

1 patients?
2 A. My review of the scientific evidence and the double-blind
3 controlled clinical trials is that there -- that paroxetine
4 does not cause suicide.
5 Q. Have you reviewed the medical and scientific literature to
6 assess the question of whether paroxetine or Paxil causes
7 suicidality in adults?
8 A. I have, and it does not.
9 Q. Having looked -- having looked at all the data you've
10 addressed, what is your opinion as a practicing psychiatrist
11 who's treating patients as to whether there's a cause and
12 effect relationship between paroxetine and suicidal behavior
13 or completed suicide in adult patients?
14 A. There is no relationship.
15 Q. Have you seen any evidence that Paxil or paroxetine causes
16 or induces suicidal behavior or completed suicides in patients
17 Mr. Dolin's age, that is, 57 years old?
18 A. No. If anything, the trend is to protect against suicide.
19 Q. Did your review and analysis of the available data on the
20 question of whether there's a causal relationship between
21 paroxetine and adult suicidality factor in to the opinions
22 you're offering here today?
23 A. Yes.
24 Q. The jury has heard from Dr. Healy, who testified that he
25 believes there are three different mechanisms -- primary

1 mechanisms by which paroxetine can induce suicidality. Are
2 you familiar with Dr. Healy's theories?
3 A. I am.
4 Q. Okay. Turn in your book to Tab 2.
5 MR. BAYMAN: Your Honor, I'd ask for permission to
6 publish this. The jury's seen it through Dr. Healy.
7 MR. RAPOPORT: No objection.
8 THE COURT: What?
9 MR. RAPOPORT: I slurred it together. I said, "No
10 objection."
11 THE COURT: No objection. Okay. Let me see it.
12 Okay. I've got it.
13 BY MR. BAYMAN:
14 Q. Now, do you agree with Dr. Healy's position that Paxil or
15 paroxetine can induce suicidality in adult patients?
16 A. I do not.
17 Q. And Dr. Healy has testified that the three primary
18 mechanisms by which paroxetine does induce suicidality are
19 shown in this graphic. I want you to assume that. Okay?
20 A. Okay.
21 Q. I know you don't agree with it, but can you use the
22 graphic to explain the concept of a biological mechanism?
23 A. Well, a biological mechanism would be the mechanism by
24 which some side effect or something occurs. I'll give you an
25 example. Say someone's on aspirin and bleeding. So, some --

1 we know that bleeding can be a side effect of aspirin in some
2 people.
3 The mechanism of action is that aspirin inhibits
4 platelet aggregation. Platelets are involved in --
5 aggregate -- keeps the platelets -- aspirin keeps the
6 platelets from clumping and making a clot. And if you inhibit
7 the platelets from doing that, you can get bleeding. That's
8 an example of a mechanism of action.
9 Q. Is there an established mechanism for SSRIs like Paxil or
10 paroxetine causing suicide?
11 A. Well, no, there's no established mechanism; and it also
12 doesn't do that, so it's kind of silly in some ways to be
13 thinking of a mechanism, but I guess Dr. Healy has proposed
14 one. But the data doesn't show that Paxil causes suicide
15 anyway. The title is wrong.
16 Q. Well, let's look at his graphic on mechanisms of action.
17 What is emotional blunting?
18 A. Emotional blunting would be somebody who cannot show
19 emotions, can't laugh, can't cry. It can also be someone just
20 doesn't care about anything, doesn't care if they have no
21 energy, doesn't care if -- what's happening to their family.
22 That would be emotional blunting, no emotions.
23 Q. If someone was weepy, would they be experiencing emotional
24 blunt being?
25 A. No, no, no.

1 Q. And what is decompensation, which Dr. Healy has also
2 called psychotic decompensation?
3 A. Right. So, I mean, I've seen Dr. Healy refer to it as
4 psychotic decompensation. That would mean someone has become
5 psychotic, and by definition, psychotic means having
6 hallucinations or delusions.
7 Q. And we talked about akathisia.
8 A. Yes.
9 Q. And do you agree that Paxil can induce suicidal behavior
10 through one of these mechanisms?
11 A. No, I don't. And by the way, since this case is about
12 Mr. Dolin, Mr. Dolin didn't exhibit --
13 THE COURT: Doctor, please. Don't volunteer. The
14 lawyer will ask you questions. We have enough questions to
15 answer here without adding to it.
16 THE WITNESS: I'm sorry.
17 THE COURT: I'm sure he's going to get to this.
18 MR. BAYMAN: I will, your Honor.
19 THE COURT: I'm going to caution you again, please
20 just answer questions without volunteering anything.
21 THE WITNESS: Sure.
22 THE COURT: Okay. Thanks.
23 BY MR. BAYMAN:
24 Q. Based on your review of the materials in this matter and
25 your own experience, your own professional experience, has FDA

1 found a support for a causal relationship between SSRI
2 treatment or paroxetine or Paxil treatment specifically and
3 suicide in adults?
4 MR. RAPOPORT: Objection, your Honor. He doesn't
5 speak for the FDA.
6 THE COURT: Sustained.
7 BY MR. BAYMAN:
8 Q. Have you seen FDA's position in any of the materials that
9 you've reviewed?
10 A. Yes.
11 Q. Have you seen anywhere where FDA has found support for a
12 causal relationship between SSRI treatment or Paxil or
13 paroxetine treatment specifically and suicide?
14 A. No.
15 MR. RAPOPORT: Same objection.
16 THE COURT: The answer slipped out already. Well,
17 we've got it, so let's go on to something else.
18 BY MR. BAYMAN:
19 Q. In -- you mentioned your work in clinical trials. Have
20 you been a clinical trial investigator?
21 A. Yes, for most of my career.
22 Q. What does a clinical trial investigator do?
23 A. Well, we do a number of different things. We -- a lot of
24 it is studying new medications that are not yet on the market.
25 We're in the middle of some trials right now. It's

1 potentially very new and different treatments for depression
2 and anxiety.
3 Sometimes we study medications that are already on
4 the market. Most of my research with the National Institute
5 of Mental Health has been to find new uses for medications
6 that are already on the market.
7 But it involves enrolling patients, treating
8 patients. If you were to watch me doing these clinical
9 trials, you might not be able to tell the difference between
10 what I do with my patients on the research studies compared to
11 my patients who are just in the outpatient clinic. But the
12 difference is they're on a protocol. The medicine is blinded,
13 and they're doing a lot of rating scales to assess how they're
14 doing.
15 Q. And do you consult with pharmaceutical companies about the
16 design or the execution of clinical trials?
17 A. Yes.
18 Q. Is there anything inappropriate about that?
19 A. No. I mean, I'm an independent person. I do it if I have
20 the time and the interest. But in some of my areas of
21 interest, I've actually been urging pharmaceutical companies,
22 "We need somebody to study this," for example.
23 Q. Does the fact that you've consulted with pharmaceutical
24 companies, does that bias your opinions in any way?
25 A. No.

1 Q. In your practice as a psychiatrist treating patients and
2 also as someone who teaches medical students and who lectures,
3 do you look at prescription drug labels for the medications
4 you prescribe?
5 A. Yes.
6 Q. Why do you do that?
7 A. Well, there's a lot of information contained in the
8 prescription drug label; and particularly when I'm teaching
9 students, medical students and residents, I teach them about
10 reading the label.
11 Q. And do you review the entire label when you look at a drug
12 label in making a decision whether to prescribe a medicine?
13 A. Of course. You read the whole thing.
14 Q. Why do you do that, and why do you instruct your students
15 to do that?
16 A. Well, I mean, there's no, like, *Cliff Notes* or *Reader's*
17 *Digest* version of the label. I mean, doctors are used to
18 reading labels. You read the whole thing because there's all
19 kinds of information.
20 You know, when a new drug comes out, you read it for
21 the first time; but it also serves as a reference -- I can't
22 memorize everything that's in the label, but it's a
23 reference -- they actually put it in a book called the *PDR*,
24 which most doctors have on their shelves, and it's a
25 reference. But at the beginning, you read the whole label.

1 MR. BAYMAN: Your Honor, permission to publish Joint
2 Exhibit 1, which has already been admitted into evidence,
3 which the label.
4 It's at Tab 3 in your book, Doctor.
5 THE COURT: You may proceed.
6 BY MR. BAYMAN:
7 Q. Doctor, this is -- the jury's seen this. This is the
8 Paxil label that was in effect in 2010. Let's blow up the box
9 warning.
10 Are you familiar with the language in the box
11 warning?
12 A. Yes.
13 Q. And did -- does the box warning address whether
14 placebo-controlled trials of SSRIs found an increased risk in
15 suicidality in adults over 24?
16 A. Yes, it does.
17 Q. And as a practicing psychiatrist and as one who teaches
18 medical students, what does it mean to you, the phrase,
19 "Patients of all ages who are started on an antidepressant
20 therapy should be monitored appropriately and observed closely
21 for clinical worsening, suicidality, or unusual changes in
22 behavior"?
23 A. Well, let me say a couple of things about the label. This
24 is -- as you pointed out, this is the black box warning. It's
25 the first thing that appears in the label. And the

1 FDA-approved label says, "Short-term studies did not show an
2 increase in risk of suicidality beyond the age of 24." But it
3 also says in the black box, "Patients of all ages who are
4 started on an antidepressant should be monitored appropriately
5 and observed closely for worse -- clinical worsening, suicidal
6 behavior or thinking, or unusual changes in behavior."
7 And this is -- you know, this is not -- this is good
8 advice. I mean, all patients who are started on
9 antidepressants should be monitored. I'm not sure doctors
10 need to be told that, but they are told that in this label.
11 And it's very clear. All ages should be monitored.
12 Q. I ask you to assume that Dr. Glenmullen has testified that
13 this phrase, "Depression in certain other psychiatric
14 disorders are themselves associated with increases in the risk
15 of suicide."
16 A. Yeah.
17 Q. In your opinion, does that warn -- does that tell a
18 prescriber that these drugs might not cause some risk to adult
19 patients over 24, risk of suicidality in taking them?
20 A. No, I wouldn't agree it says that. I mean, it's true that
21 depression and other disorders increase the risk of suicide,
22 but it doesn't say, "Don't monitor -- therefore, don't monitor
23 your patients." It says in the label of a drug, in this case
24 paroxetine, "Monitor your patients regardless of their age for
25 worsening and suicidality." It's in the drug label.

1 Q. And, Doctor, Dr. Glenmullen also testified that the
2 depression sentence that I just read and the patients of all
3 ages sentence that you read means, "Don't worry if it's a
4 patient over age 25. It's not the drug. It's the
5 depression." Do you agree with that?
6 A. No. It doesn't say that. It doesn't say, "Don't worry."
7 It doesn't say -- it says, "Monitor the patients regardless
8 of -- of all ages." I mean, that -- you can't be more clear
9 than that, that you need to monitor your patients for clinical
10 worsening, suicidality, and unusual changes in behavior.
11 By the way, the next sentence is important, too,
12 where it says, "Families and caregivers should be advised of
13 the need for close observation and communication with the
14 prescriber of the medication." So, it's not just patient, but
15 it's also their family and or their caregivers.
16 Q. Dr. Glenmullen also testified that if he was treating a
17 57-year-old patient and put them on Paxil, that warning means
18 to him that Paxil couldn't make them worse, Paxil couldn't
19 make them suicidal. Do you agree with that?
20 A. No. It says, "All ages should be monitored." It doesn't
21 say, "Don't worry if you're treating a 57-year-old." It says,
22 "All ages should be monitored." I do not agree with that.
23 Q. In addition to the black box, what section of the labeling
24 would you go to next to look for a potential risk of
25 suicidality?

1 A. Well, if you were interested in that topic, you would go
2 to the "Warnings" section next.
3 Q. Let's pull that up quickly.
4 Now, would you ever recommend to a physician
5 encountering this label to stop at the black box section?
6 A. No, no. You need to read -- physicians need -- I tell my
7 students, you need to read the whole label. Again, this is
8 not -- the black box is not a *Cliff Notes* version. You need
9 to read the entire thing.
10 Q. I want to just -- the "Warnings" section. And the jury
11 has seen this. We're not going to go through -- go through it
12 all. I just want to ask you why -- why this section is
13 important to you as a prescribing physician and what it tells
14 you.
15 A. Well, again, it's -- it's telling me, as a doctor
16 prescribing a medication -- it says that there's no increased
17 risk of suicidality beyond the age of 24; but it also says
18 that there has been a longstanding concern that
19 antidepressants may play a role in inducing worsening of
20 depression and the emergence of suicidality in certain
21 patients during early phases of treatment.
22 So, again, it's advising doctors to be on the
23 lookout, not that there's been a proven cause, but to be on
24 the lookout when treating a patient for the patient getting
25 worse or suicidal thinking developing.

1 Q. And you said something there, not a proven cause. If --
2 based on your experience with drug labels, if a manufacturer
3 does not believe their drug causes a condition, why do they
4 put warnings information in their label?
5 A. Because -- like it says here, because a concern has been
6 raised. You know, the data -- in the field of medicine, the
7 field of psychiatry, we're constantly analyzing the data.
8 More information comes in, and we're constantly analyzing it.
9 There is a concern -- it's just like my article in
10 1991. I had raised a concern. I didn't say it caused
11 anything, and with further analysis, akathisia was not causing
12 anything; but nonetheless, I wanted to alert doctors to be on
13 the lookout for things. This does kind of the same thing in
14 the drug label. It says, "We haven't been able to prove a
15 cause, but the concern has been raised, so doctors, when
16 you're treating your patients, when you're closely monitoring,
17 as it says you should, be on the lookout for this if it
18 occurs."
19 And then I think we'll talk about later, it actually
20 gives advice about what to do if it occurs.
21 Q. Why is it important to give doctors this kind of
22 information when they're making prescribing decisions?
23 A. Because as a doctor, you always are weighing the risk and
24 benefits of anything you do. We didn't focus on the benefits
25 of taking paroxetine, but you're always weighing that. And

1 the doctor needs this -- it helps the doctor to have this
2 information in order to make a decision what's best for the
3 patient.
4 Q. And when you say weighing risks and benefits, could you
5 just explain that in a little more detail?
6 A. Well, the benefits to be reducing anxiety symptoms and
7 depressive symptoms in the case of paroxetine, and the risks
8 would be any potential side effects and concerns that have
9 been raised. You have to weigh the two together.
10 But it's all -- I guess my point is, it's all in the
11 label. It's all there for the doctor to read and to make the
12 decision.
13 Q. And is that what you do as a prescribing physician? When
14 you make a decision to prescribe medicine, do you weigh the
15 risks of treating the conditions -- I mean the benefits of
16 treating the conditions versus the risk the medication may
17 pose to the patient?
18 A. I do, and I also discuss it with the person because I want
19 them to be aware of it, too.
20 Q. Let's go on to page 12 of the "Clinical Worsening." It's
21 the next page. Can you just tell us what is significant to
22 you as a practicing physician from this section on page 12 of
23 the label?
24 A. So, I guess we'll start at the top. It informs the
25 prescriber that there were suicides in the adult trials, so it

1 says there were suicides; but the number of suicides was not
2 sufficient to reach any conclusion about a drug effect on
3 suicide. So, but, it does alert the doctor that they did note
4 some suicides during the clinical trial; but in comparison to
5 the placebo, they couldn't reach any conclusions. The number
6 was very small.
7 I guess the next thing that's important is what's in
8 bold, and it's sort of repeated again. "All patients being
9 treated with antidepressants should be monitored appropriately
10 and observed closely" -- this is like, I think, the third time
11 this has been said -- "for clinical worsening, suicidality,
12 and unusual changes in behavior during the initial few months
13 of a course of drug therapy, or when the dose is increased or
14 decreased."
15 And then there's -- the next paragraph I think is
16 illustrative of something else. They then list in the label a
17 number of different symptoms: Anxiety, agitation, insomnia,
18 akathisia, which is psychomotor restlessness, hypomania,
19 mania. They talk about these things, and they say they've
20 been reported in the adult trials, and there's been these
21 observations.
22 And then I think we drop to the sentence that says,
23 "Although a causal link between the emergence of such symptoms
24 and either the worsening of depression and/or the emergence of
25 suicide impulses has not been established" -- and I already --

1 we already talked about the fact that akathisia had been
2 worked out, and it was not a factor; but it goes on to say,
3 "There is concern that such symptoms may represent precursors
4 to emerging suicidality."
5 So, in other words, some people have raised a concern
6 that these -- this list of symptoms may be a forerunner of
7 someone becoming suicidal. So, it's alerting, again, Doctors
8 and other prescribers that -- you know, to be on the lookout
9 if these things happen.
10 And then the next paragraph tells the doctor or
11 prescriber what to do -- or what to consider. "Consideration
12 should be given to changing the therapeutic regimen," so maybe
13 use a different medication, possibly discontinuing this
14 medication, the medication, in this case paroxetine, in
15 patients whose depression is persistently worse or who are
16 experiencing suicidality or symptoms that might be one of
17 those precursors, that the doctor should consider maybe
18 lowering the dose or switching the medicine or discontinuing
19 the medicine.
20 There's a lot -- you know, I'm doing it quickly, but
21 there's a lot of information just in this page.
22 Q. I want to take you back up.
23 MR. BAYMAN: And, Mr. Holtzen, will you highlight the
24 following symptoms and go all the way to the end of that
25 sentence.

1 BY MR. BAYMAN:
2 Q. I want you to assume that Dr. Glenmullen has testified
3 that akathisia is a shorthand for those other symptoms and
4 could be removed from the label. Do you agree with
5 Dr. Glenmullen that akathisia is a shorthand for the other
6 symptoms listed in the label?
7 A. No, no, no. Akathisia is one symptom, and these other
8 things are different symptoms like irritability or insomnia.
9 Those are other symptoms. They're all separate. There's no
10 shorthand -- I don't even understand that, but these are all
11 different symptoms that are distinct from each other.
12 Q. And in your opinion, is this language in this warning, is
13 this relating just to the disease of depression and anxiety,
14 or does this bear some relationship to the medicine?
15 A. No, this -- this is the medicine. I mean, it says in the
16 sentence, "being treated with antidepressants." It's from the
17 medicine. The concern is it's from the medicine.
18 Q. Let's pull up, "All patients being treated," page 12.
19 That's what you mentioned about earlier. Is there
20 any significance to you that that's in bold?
21 A. Yes. Well, if it's in bold, you know, it's highlighted.
22 I guess it gets a little more attention. I mean, this is --
23 again has been seen earlier in the label, but it's repeating
24 it once again to monitor and observe the patients closely.
25 MR. BAYMAN: Okay. Pull up the families and

1 caregivers section, Mr. Holtzen.
2 BY MR. BAYMAN:
3 Q. You mentioned this briefly earlier. Why is this
4 important?
5 A. Well, it's important because it's more eyes on the -- the
6 label is advising that the people who are living with or
7 caring for the patient or may be seeing the patient every day
8 should be informed about this information and about the need
9 to monitor patients for emergence of agitation, irritability,
10 unusual changes in behavior.
11 And I think the very important part of this, this is
12 what I tell my patients and their families, is what it says
13 there about, "And if you see these things, to report such
14 symptoms immediately to the healthcare provider."
15 You know, as a doctor, I might be seeing a patient
16 once a week. That's one hour out of however many other hours
17 there are in a week. The family is the one on the scene, and
18 I can use their help. If they see anything wrong, they need
19 to call, and that's what I tell them. That's what the label
20 says, that the prescribing doctor should inform the family to
21 do that.
22 Q. Did you see anything in the testimony that you reviewed in
23 this case about whether Dr. Sachman told Mr. Dolin and
24 Mrs. Dolin to let him know if Mr. Dolin was experiencing any
25 unusual changes in behavior after he started paroxetine?

1 A. Yes, I saw Dr. Sachman's testimony, and he testified that
2 he did, in fact, do that. He told Mr. and Mrs. Dolin that.
3 Q. Did you also review the "Precautions" section of the
4 label?
5 A. I did.
6 Q. And is that -- as part of your practice, do you look at
7 "Precaution" sections in prescription medicine labels?
8 A. Yes. I already told you, I read the whole label, and
9 everyone should read the whole label.
10 Q. What's the difference between a "Warnings" section and a
11 "Precautions" section, in your experience?
12 A. The warning is a little bit higher level notification, I
13 guess, of a precaution. It's taken a little more seriously.
14 They're both important, but it's a higher level as a warning.
15 Q. Can we pull up the clinical worsening precaution.
16 Again, why is this significant to you as a practicing
17 psychiatrist?
18 A. Again, it's informing the prescribing doctor, and it's
19 again repeating something we saw earlier about this list of
20 symptoms. But it's basically saying that patients, the
21 families, their caregivers should be encouraged to be alert
22 to the emergence of these various symptoms, which we've talked
23 about, akathisia, anxiety, agitation, insomnia, worsening of
24 depression, suicidal ideation, especially early during
25 antidepressant treatment and when the dose is changed up or

1 down.

2 And again, it advises that the family and caregivers

3 of the patients should be advised to look out for these things

4 on a day-to-day basis since the changes may be abrupt. And

5 then such symptoms should be reported, again, it repeats what

6 it said earlier, to the patient's prescriber or healthcare

7 professional, even if they are -- especially if they are

8 severe.

9 Q. Let's pull up the akathisia precaution. Are you familiar

10 with the precaution for akathisia in the Paxil label?

11 A. Yes. There's a separate paragraph on akathisia.

12 Q. And what does that akathisia precaution mean to you as a

13 prescribing physician?

14 A. So, what this says is that the use of paroxetine and also

15 other SSRIs has been associated with the development of

16 akathisia, characterized by an inner sense of restlessness and

17 psychomotor agitation, such as -- which I told you earlier,

18 such as inability to sit or stand still, usually associated

19 with subjective distress. This is most likely to occur within

20 the first few weeks of treatment.

21 So, it sort of defines what it is. It says it can

22 happen. It's one of the things on the list that the doctor,

23 the family, and the caregivers need to look out for. It's

24 just again sort of alerting doctors of this possibility.

25 Q. In your opinion, is that description of akathisia in the

1 Paxil label an accurate description?
2 A. Yes.
3 Q. Now, does the Paxil label today contain all of the various
4 warnings and precautions that we've covered here?
5 A. Yes, it does.
6 Q. In your opinion as a practicing psychiatrist who
7 prescribing these kinds of medications, do you believe that
8 the labeling adequately instructs you to monitor all of your
9 patients of all ages for the emergence of symptoms that may be
10 precursors to suicidality or worsening depression for patients
11 who are taking Paxil or paroxetine?
12 A. Yes. I think it's very adequate, a lot of information.
13 Q. Now, the jury's heard Dr. Glenmullen testify that the
14 Paxil label does not -- tells doctors that an increased risk
15 of suicide does not happen to people over age 24. Do you
16 agree with that?
17 MR. RAPOPORT: Your Honor, I just want to interpose
18 an objection that by staying silent here, we're not agreeing
19 to counsel's characterizations of bits and pieces of what
20 Dr. Glenmullen testified to. To keep this moving, I'm not
21 going to ask to strike anything, but I just want it on the
22 record that we don't believe in these snippets.
23 MR. BAYMAN: I'm happy to pull the trial testimony if
24 we need to do it that way, your Honor.
25 THE COURT: Well, at the moment it's not an

1 objection, so go ahead.
2 BY MR. BAYMAN:
3 Q. Do you agree with that?
4 A. I'm sorry. Could you repeat the question.
5 THE COURT: Read it back.
6 (Record read.)
7 BY THE WITNESS:
8 A. Well, no, it doesn't -- I mean, it doesn't say that. It
9 doesn't say, "Don't worry about your patients over age 24."
10 It says that no causal relationship has been found with
11 paroxetine and suicide above age 25, but it says multiple
12 times that suicides -- that patients need to be monitored, all
13 ages. It doesn't say, "Don't worry if you're 25 or older."
14 It says monitor the patients of all ages. And then actually
15 we talked about, it says suicides occurred in adults in the
16 clinical trials.
17 So, I don't see how you could interpret this as you
18 don't have a care in the world if they're 25 or older.
19 BY MR. BAYMAN:
20 Q. Monitor patients of all ages for what?
21 A. For all of things we've been talking about, suicide,
22 suicidality, suicidal behavior, akathisia, that the patients
23 of all ages need to be monitored for that, and also the
24 families and caregivers need to be informed to monitor for
25 that as well.

1 Q. Dr. Glenmullen, I'll ask you to assume, has also testified
2 that the "Warnings" section of the label and those symptoms
3 that you've listed tells him that the symptoms listed in the
4 label cannot lead to suicide in someone Mr. Dolin's age.
5 MR. RAPOPORT: Objection, your Honor.
6 Mischaracterization of the testimony. We would ask that if
7 this is going to be done, it should be to specific quotes.
8 MR. BAYMAN: It's --
9 THE COURT: Give him the specific quote.
10 MR. BAYMAN: Yeah. Trial transcript, page 1919,
11 line 9, 9 to 15.
12 MR. RAPOPORT: Wait. I'll have it in one second,
13 your Honor.
14 MR. BAYMAN: Sure.
15 MR. RAPOPORT: Do you have the date on it?
16 MR. BAYMAN: March 29th.
17 MR. RAPOPORT: A.m., p.m.?
18 MR. BAYMAN: A.m.
19 MR. RAPOPORT: It's the middle of an answer. I
20 object to it, your Honor. These things are out of context
21 snippets that are being taken.
22 MR. BAYMAN: I'll read the whole answer -- well,
23 actually, I won't, because it goes about three pages, so --
24 THE COURT: You can't do that.
25 BY MR. BAYMAN:

1 Q. Would you agree that the label says that these symptoms
2 cannot lead to suicide in someone of Mr. Dolin's age?
3 A. No, I would not agree. In fact, it says there is concern
4 that such symptoms may represent precursors to emergent
5 suicidality.
6 Q. Would you agree that -- do you agree that the label says
7 that a patient couldn't possibly become worse on paroxetine?
8 A. No, it doesn't say that. It says they could become worse.
9 Q. Now, we talked about the black box a minute ago, and I
10 believe you testified you shouldn't look just -- a doctor
11 shouldn't look just at the black box, but should look at
12 the whole label?
13 A. Correct.
14 Q. Do you know form your review of the materials in this case
15 whether Dr. Sachman, Mr. Dolin's prescribing doctor, said he
16 reviewed the whole label or just the black box?
17 A. I saw testimony from Dr. Sachman that he reviewed the
18 entire label.
19 Q. I want to shift gears, Doctor, and talk a little bit about
20 depression and anxiety. What are the main psychological
21 disorders that are risk factors for suicide?
22 A. The big three would be anxiety disorders, mood disorders
23 such as depression, and substance abuse.
24 Q. Does having anxiety or depression have an impact on the
25 risk that an individual may commit suicide?

1 A. Yes. If someone's suffering from an anxiety disorder,
2 they're at a 16 times higher risk of committing suicide than
3 someone who does not have an anxiety disorder. If they also
4 have depression, the risk goes up even further. So, they're
5 big risk factors.
6 Q. Based on your research and your experience, have
7 suicide -- suicides occurred for as long as we've been
8 recording history?
9 A. Yes. And actually, another thought I had about your other
10 question, you know, if you look at -- the CDC, the Centers for
11 Disease Control, has looked at suicides in the United States.
12 90 percent of the suicides had a psychiatric disorder, either
13 depression, anxiety, or substance abuse. So, that's where
14 that comes from.
15 Q. Were people committing suicides before SSRIs and other
16 antidepressants came on the market?
17 A. Yes.
18 Q. And as a practicing psychiatrist who treats patients and
19 also teaches, do you stay current on the medical and
20 scientific literature relating to suicide?
21 A. I do.
22 Q. What is the biggest risk factor for suicide?
23 A. Well, the biggest risk factor is untreated or inadequately
24 treated depression.
25 Q. Is there an association between untreated and inadequately

1 treated depression and suicide?
2 A. Yes, a big one. It's the biggest risk factor.
3 Q. As a practicing psychiatrist and also someone who lectures
4 on this topic, do you review statistics on suicide in the
5 United States in the course of your practice?
6 A. Yes, it's part of my job.
7 Q. As a psychiatrist and a lecturer, what's the importance to
8 you of the nationwide statistics regarding which patient
9 populations are more likely than others to commit suicide?
10 A. Well, it gives me as a practicing psychiatrist a
11 background of what the risks may be for the person sitting in
12 my office.
13 Q. Tell the jury what you mean by that.
14 A. Well, we've already discussed that, you know, anxiety,
15 generalized anxiety disorders, the risk is 16 times higher
16 than the general population. If someone also has depression,
17 it's a big risk factor.
18 There are certain professionals that have higher
19 rates of suicide. Lawyers are No. 4. Doctors, dentists,
20 pharmacists are the top three, that mainly because they have
21 access to means; but attorneys are No. 4.
22 MR. RAPOPORT: Your Honor, I hate to interrupt the
23 answer, but I do think this steps over a line that you drew,
24 and I would move to strike it.
25 THE COURT: I'm going to allow a limited amount of

1 information, but I certainly have ruled that we're not going
2 into statistics of suicides. It's not part of this case, and
3 I will strike it if I hear it. But I will allow a certain
4 amount of this in order to understand the doctor's testimony.
5 Do you understand me, Doctor? We're not going into
6 national suicide numbers and things of that kind. So, don't
7 go into it.
8 THE WITNESS: Okay. Well, stop me if I do something
9 wrong.
10 THE COURT: Well, I will, or they'll object, which is
11 more likely the case.
12 BY THE WITNESS:
13 A. Well, what I was going to say was if I have a patient in
14 my office and knowing that they're a certain profession, you
15 know, that's a factor that I have to take into account.
16 You know, if you're talking about attorneys, there
17 have been surveys of one in four attorneys in North Carolina
18 suffered from anxiety. 11 percent had suicidal ideation at
19 least once a month in the past year in that North Carolina
20 survey.
21 Suicide's the third-leading cause of death amongst
22 lawyers after cancer and heart disease. The rate of
23 depression in attorneys is 3. -- if you control for age and
24 economic status and gender, the men -- male attorneys have a
25 3.6 times higher rate of suicide than men who are not

1 attorneys.
2 So, I mean, these things are -- they're factors when
3 you're seeing a patient. It helps to know these things when
4 you're seeing a particular patient.
5 BY MR. BAYMAN:
6 Q. Is suicide more common among men --
7 MR. RAPOPORT: Show a continuing objection to this,
8 your Honor.
9 THE COURT: Proceed.
10 BY MR. BAYMAN:
11 Q. Is suicide more common among men or women?
12 A. Men.
13 Q. Have you -- in the course of your practice and research,
14 have you looked at the issue of suicide in men of Mr. Dolin's
15 age group in particular?
16 A. Yes.
17 Q. And what does that tell you?
18 A. Well, the rate of suicide in men of the Baby Boom
19 generation, and Mr. Dolin's age was, has been increasing
20 unfortunately. If you go back to 2010, 43 percent of the
21 suicides in the United States that year were men in
22 Mr. Dolin's age group.
23 Q. What age group was that?
24 A. 35 to 64.
25 Q. And what do -- what does the data reveal about the number

1 of suicides in the United States in 2010?
2 A. It was over 38,000.
3 Q. And how does that average out?
4 A. Well, it's about one every 14 minutes, like 105 suicides a
5 day. I think in Illinois, there were 1200 in 2010.
6 Q. All right. Let's talk about Mr. Dolin, because this case
7 is about him.
8 Have you reviewed Mr. Dolin's records in this case?
9 A. I have.
10 Q. Have you reviewed his therapy records?
11 A. Yes.
12 Q. Have you reviewed the materials produced by his law firm,
13 Reed Smith?
14 A. Yes.
15 Q. Have you worked with me and my team before trial and
16 recently to develop some timelines that summarize Mr. Dolin's
17 therapy so that we don't have to look at each and every
18 therapy record?
19 A. Yes. I tried to synthesize it into kind of a short
20 summary.
21 Q. Just so you know, the jury's already seen those records
22 through the testimony of Dr. Sahlstrom and Ms. Reed.
23 A. Okay.
24 MR. BAYMAN: Your Honor, at this point, I would --
25 counsel, behind Tab 20, it's the second document.

1 I would ask for permission to publish for
2 demonstrative purposes the first graphic timeline which
3 summarizes what Dr. Rothschild has felt significant from his
4 review of the records at a particular time.
5 THE COURT: And the number is?
6 MR. BAYMAN: It's DX 7038-2, behind Tab 20 in your
7 book, your Honor. It should be right after his opinions.
8 MR. RAPOPORT: No objection to showing it.
9 THE COURT: All right.
10 BY MR. BAYMAN:
11 Q. When -- based on your work in this case, when is the first
12 time that you're aware of that Mr. Dolin sought mental health
13 treatment?
14 A. 1989.
15 Q. Had Mr. Dolin experienced anxiety and depression prior to
16 1989?
17 A. Yes. There was -- I saw testimony from Mrs. Dolin that
18 he had symptoms of anxiety after graduation from law school
19 and I think going to his first job.
20 Q. Do we have earlier records prior to 1989 of Mr. Dolin?
21 A. No.
22 Q. From whom did Mr. Dolin seek treatment in 1989?
23 A. He saw a Dr. Roth, who was a psychiatrist.
24 Q. And was Mr. Dolin going through any changes in work -- at
25 work in September of 1989 when he started treating with

1 Dr. Roth?
2 A. Yes. It coincides with the time that he was joining the
3 law firm Sachnoff & Weaver.
4 Q. Did Dr. Roth diagnose Mr. Dolin?
5 A. Yes.
6 Q. What did he diagnose him with?
7 A. Anxiety.
8 Q. How do you know that?
9 A. Well, unfortunately, there are no records from then, but
10 the billing records, I was able to look at; and when you do a
11 billing record, you have to put a diagnosis, and that's what
12 was on there.
13 Q. Do we have any more detail about Dr. Roth's treatment of
14 Mr. Dolin, including whether he prescribed medication to him?
15 A. No. What I was able to learn from the billing records,
16 that he saw Dr. Roth approximately 70 times over a seven-year
17 period.
18 Q. So, what -- in your opinion, was Mr. Dolin under
19 Dr. Roth's care?
20 A. Yes. Well, 70 times to see a patient, it's quite a number
21 of times. I mean, you're seeing him I guess an average of
22 once a month, so that would be ongoing care for seven years.
23 Q. In your opinion, what does this anxiety diagnosis back in
24 1989 and the duration of treatment with Dr. Roth tell you
25 about Mr. Dolin's psychiatric condition, if anything?

1 A. Well, sir, it tells me that he needed -- Mr. Dolin needed
2 monitoring. He wasn't like a one-shot deal, "You're fine. I
3 don't need to see you back." He was monitoring him for
4 seven years, approximately once a month. So, that's -- you
5 know, it's an ongoing problem. Let's put it that way.
6 Q. And Dr. Glenmullen testified Mr. Dolin saw Dr. Roth off
7 and on, somewhat sporadically. Does that mean his condition
8 was mild?
9 A. No. First of all, I wouldn't agree that it was sporadic.
10 He saw him 70 times over seven years. That's about
11 approximately once a month. And I don't know how you could
12 know without the records that it was mild. All we know is
13 that he had seven years of treatment, 70 visits.
14 Q. Now, based on your professional experience in treating
15 patients, does psychiatric illness get worse as patients get
16 older?
17 A. Unfortunately, yes. It's like other diseases. If you
18 follow people over time, the diseases often worsen as people
19 get older.
20 Q. When is the next time after Dr. Roth that we have a record
21 of Mr. Dolin being treated for anxiety?
22 A. Well, in 2005, the records show that Dr. Sachman treated
23 him for anxiety with paroxetine.
24 Q. And what dosage was prescribed?
25 A. 10 milligrams, 10 milligrams a day.

1 Q. What is the recommended starting paroxetine dose for
2 treating anxiety or depression?
3 A. 20, 20 milligrams per day.
4 Q. Dr. Rothschild, have you seen any evidence that Paxil or
5 paroxetine in a 10-milligram dosage can cause or induce
6 suicidal behavior or suicide in adults?
7 A. No.
8 Q. Have you seen it at any dose?
9 A. No.
10 Q. How long did Mr. Dolin remain on 10 milligrams a day of
11 paroxetine?
12 A. Approximately 13 months.
13 Q. Did you assist in preparing a graphic or demonstrative
14 outlining how many paroxetine pills Mr. Dolin took in 2005
15 and 2006?
16 A. I did.
17 Q. Would that graphic be helpful to illustrate your testimony
18 to the jury?
19 A. I think it's easier to see it pictorially, yes.
20 MR. BAYMAN: Your Honor, at this point, I move for
21 permission to publish DX 7038-3.
22 MR. RAPOPORT: No objection.
23 BY MR. BAYMAN:
24 Q. How long did Mr. Dolin take paroxetine in 2005 and 2006?
25 A. Well, he filled 13 prescriptions, so it's a little over a

1 year. There's some gaps in there, but it was a little over a
2 year. So, from October, early October of 2005 into probably
3 the end of November 2006.
4 Q. If he took paroxetine as prescribed, when would he have
5 run out of paroxetine?
6 A. Well, the last prescription was picked up October 29th,
7 2006. It was a 30-day supply, so it would be the end of
8 November 2006.
9 Q. How many pills did he take over this time period?
10 A. Each prescription was for 30 pills. 13 times 30 is 390,
11 390 pills.
12 Q. Was there any evidence in the medical records or the
13 testimony that you've seen that Mr. Dolin experienced any
14 side effects or problems whatsoever related to taking 390
15 paroxetine pills for over a year?
16 A. None. Actually, the medical records show that he did well
17 on it.
18 Q. Did Mr. Dolin take Paxil, or did he take generic
19 paroxetine?
20 A. I think it was generic paroxetine.
21 Q. Did you see any testimony from Dr. Sachman about whether
22 he would inquire of Mr. Dolin about how he was doing after
23 Dr. Sachman prescribed medicine to him?
24 A. Dr. Sachman, I saw his testimony, said that he would
25 inquire about whether Mr. Dolin was having any problems with

1 the medication.
2 Q. And how did -- what did Mr. Dolin report to Dr. Sachman
3 about how he did on paroxetine in 2005 and 2006?
4 A. Mr. Dolin reported that he did well on it.
5 Q. Did Mr. Dolin report any symptoms consistent with
6 akathisia?
7 A. No.
8 Q. While he was taking paroxetine from 2005 and then again
9 into 2006, did he report any suicidal thoughts?
10 A. No.
11 Q. At any time -- based on your review of the records and the
12 testimony, at any time when Mr. Dolin took paroxetine from
13 2005 into 2006, did Mr. Dolin report to Dr. Sachman any other
14 signs of increasing anxiety, agitation, depression, or any
15 worsening of his condition?
16 A. No, he did not.
17 Q. What does that tell you about how Mr. Dolin responded to
18 the paroxetine?
19 A. It tells me that Mr. Dolin responded well. He had a
20 beneficial effect from the paroxetine on his anxiety, and he
21 had no side effects.
22 Q. Now, you mentioned that there were some gaps in his use of
23 paroxetine. Do the pharmacy records indicate whether
24 Mr. Dolin took paroxetine consistently in 2005 and 2006?
25 A. He did not. There -- as I've illustrated here, there were

1 gaps when he didn't take it.
2 Q. What does that tell you about Mr. Dolin's medication
3 compliance?
4 A. Well, unfortunately, he wasn't always compliant with
5 taking the medicines. You're supposed to take the
6 antidepressant paroxetine every day religiously, and so he
7 wasn't compliant.
8 It also tells me something else. And I know a lot
9 has been made about my article and this challenge,
10 de-challenge, rechallenge. That's what --
11 THE COURT: Doctor, please. No volunteering. He'll
12 ask you a question.
13 MR. RAPOPORT: Well, now I also object to the
14 reference to non-compliance unless it's causally tied.
15 THE COURT: Well, put another question.
16 MR. BAYMAN: Yes, sir.
17 BY MR. BAYMAN:
18 Q. What does the fact that there were some stop -- Mr. Dolin
19 stopping and starting paroxetine during the time he took it in
20 2005 and 2006, what does that tell you?
21 A. Well, what I was saying is a lot's been made about this
22 challenge, de-challenge, rechallenge. That's what was going
23 on here in a way, right? Mr. Dolin was stopping the medicine,
24 de-challenge, restarting the medicine, rechallenge. He did it
25 at least twice. You know, everything was fine. There were no

1 problems. He didn't have any side effects and reported
2 nothing to Dr. Sachman about any problems.
3 Q. Now --
4 THE COURT: But Dr. Roth was treating him here,
5 wasn't he?
6 MR. BAYMAN: No, sir. This is Dr. Sachman. This is
7 2005 to 2006.
8 THE COURT: Oh, you've moved to 2005?
9 MR. BAYMAN: Yes.
10 THE COURT: Well, then take down that --
11 MR. BAYMAN: No, this is 2005 and 2006. These are
12 his prescriptions of paroxetine, Dr. Sachman.
13 THE COURT: Okay. You're counting the 390 pills from
14 both Dr. Roth and Dr. --
15 MR. BAYMAN: No. Dr. Roth didn't prescribe Paxil,
16 just Dr. Sachman. These are all Dr. Sachman.
17 THE COURT: All Dr. Sachman. Okay.
18 MR. BAYMAN: Yes.
19 BY MR. BAYMAN:
20 Q. Now, the jury heard that Mr. Dolin may have taken
21 paroxetine prior to 2005, possibly in the 2003 time frame.
22 Are you familiar with that possibility based on your review of
23 the records in this case?
24 A. Yes. I saw a record from another doctor that sort of
25 mentioned in 2003 that he was on paroxetine at the time.

1 Q. Did you see anything beyond that?
2 A. No. It was actually a one-time record, but it indicated
3 he may have been on paroxetine before 2005.
4 Q. If Mr. Dolin had taken paroxetine for a time prior to
5 2005, does that change your opinions in this case?
6 A. No.
7 Q. Does it support your opinions?
8 A. Well, yes, that would be another time that Mr. Dolin took
9 paroxetine and didn't become suicidal or something like that.
10 It's just more evidence that Mr. Dolin took paroxetine without
11 problems.
12 MR. BAYMAN: Set that down, Mr. Holtzen.
13 BY MR. BAYMAN:
14 Q. Now, did Mr. Dolin report the return of his anxiety at
15 some pointed shortly after he stopped taking paroxetine in
16 November of 2006?
17 A. Yes.
18 Q. When do we know, from the therapist's records, that
19 Mr. Dolin reported experiencing anxiety the next time after
20 November 2006?
21 A. Well, he went to see a therapist, a Ms. Reed, in February
22 of 2007.
23 Q. How do you know that?
24 A. I know that from reviewing Miss Reed's records.
25 Q. Who is Sydney Reed?

1 A. Sydney Reed is a social worker who Mr. Dolin saw for
2 therapy.
3 Q. What's the difference between a social worker and a
4 psychologist?
5 A. Well, a social worker goes to school for two years after
6 undergraduate. The degree is usually what's called a Master's
7 in Social Work. And they do some -- for licensing, they do
8 some additional clinical hours in training.
9 A psychologist is someone who goes -- gets a Ph.D. or
10 a scientific degree, and that would be about four years after
11 college. And then a psychiatrist -- do you want me to talk
12 about that, too?
13 Q. I was just going to ask you the next question, you as a
14 psychiatrist, how is your training different?
15 A. So, a psychiatrist is a medical doctor. We go to medical
16 school. And we become psychiatrists after medical school.
17 Some people become surgeons. Some people become
18 ophthalmologists. We become psychiatrists. So, we do four
19 years of additional training after medical school to become
20 psychiatrists.
21 Q. Can social workers or psychologists prescribe medications?
22 A. Social workers, definitely not. In some states,
23 psychologists can; but in most of the states of the United
24 States, they cannot.
25 Q. Now, based on your review of the medical and the pharmacy

1 records, was Mr. Dolin taking paroxetine or any other
2 medication for anxiety in early 2007 when he went to see
3 Ms. Reed?
4 A. No, he was not.
5 Q. Had any stressful events occurred that contributed to
6 Mr. Dolin's anxiety in early 2007?
7 A. Yes.
8 Q. What were they?
9 A. Well, the big thing was the upcoming merger of the
10 Sachnoff Weaver firm into a much larger international law firm
11 called Reed Smith, with offices all over the country and all
12 over the world.
13 MR. BAYMAN: Your Honor, at this point, permission to
14 publish defense DX 7038-4, which is the next phase of the
15 timeline.
16 MR. RAPOPORT: No objection.
17 BY MR. BAYMAN:
18 Q. This is the timeline you assisted us in preparing?
19 A. Yes.
20 Q. What were some of the issues that Mr. Dolin was facing
21 when he saw Ms. Reed for the first time in February 2007?
22 A. Well, I've highlighted just a few of the things from the
23 medical records, from Ms. Reed's records, and particularly the
24 things in red.
25 So, the first visit, he talks about how he's anxious

1 about the merger, and Ms. Reed notes that he has very extreme
2 negative thinking. And he had this feeling of not feeling
3 qualified to work at Reed Smith.
4 Q. And what about in the -- what are the other problems or
5 concerns that Mr. Dolin reported that you found significant in
6 that first session?
7 A. Well, he also had a great fear of being able to do the
8 job. And as we'll see here, Mr. Dolin had feelings of being
9 inferior, being inadequate, of not being up to the level of
10 the lawyers at Reed Smith because he hadn't been an
11 international lawyer. I think he said to himself -- he said
12 to his therapist that he hadn't gone to Harvard Law School or
13 Yale Law School. So, he went in to this thing with a lot of
14 anxiety and fears about how his performance was going to be at
15 this bigger international law firm.
16 Q. What was significant to you about his next visit on
17 February 26?
18 A. Well, on February 26, he's again very anxious, and he was
19 expressing fears to Ms. Reed that he wouldn't be able to
20 support himself or his family. He even used the phrase
21 "bag lady," that he would become a bag lady.
22 And the interesting thing to me was that Ms. Reed
23 noted that he was having a hard time holding it together. Now
24 the merger was about to happen and was -- I think it happened
25 in March. And he had this feeling of wanting to escape, of

1 wanting to get up, run and escape, and get out of there. But
2 it was work-related, get out of the work situation.
3 Q. Did he express any financial concerns or insecurities at
4 that time?
5 A. Yes. He was, I believe, supporting his wife's family, and
6 that was a -- he felt he had no financial backstop. And then
7 he talks about that a little more in a subsequent visit, but
8 he was worried about finances.
9 Q. Now, you talked -- you just mentioned the financial
10 concerns. You've had access to the Reed Smith records to see
11 how much Mr. Dolin was making at Sachnoff & Weaver and at Reed
12 Smith?
13 A. Yes.
14 Q. Roughly at this point in time in about 2007, about how
15 much was he making?
16 A. It was somewhere around a million dollars a year.
17 Q. In your experience as a practicing psychiatrist who has
18 treated patients were anxiety and depression, are people with
19 high financial status immune from depression and anxiety?
20 A. Not at all. I mean, in my practice, I have people who --
21 if you looked at them from the outside, you'd say, "Why are
22 they depressed? Why are they anxious? They have more money
23 than they know what to do with." But that doesn't protect
24 people. Sometimes people's anxieties are related to their
25 perception of things, not the actual dollar amount that

1 they're earning.
2 Q. And based on your review of Ms. Reed's notes, was
3 Mr. Dolin having difficulty containing his anxiety during this
4 period?
5 A. Yes. He had this feeling -- well, she wrote that he was
6 having a hard time holding it together and that he wanted to
7 get up and run.
8 Q. And during this same time period, how was Mr. Dolin
9 functioning at work and socially, based on your review of the
10 testimony and the records in the case?
11 A. Well, to the outside world, Mr. Dolin seemed fine. I
12 mean, he was functioning at work. He was interacting
13 socially. This was all inside. He didn't tell his
14 colleagues, "I feel inferior, and I don't feel I can hack
15 this." That was inside. The outside world, he had a public
16 persona that he presented to the outside.
17 Q. Tell the jury, just summarize what was important to you
18 about what he was reporting to Ms. Reed in May and June of
19 2007.
20 A. Well, it's on a similar vein. You know, he had -- he was
21 afraid that fear will make him stop functioning. His life is
22 totally different in the new law firm. And that was true. I
23 mean, it's a much bigger law firm than what he had been used
24 to.
25 In the May 26th visit, he says he's frozen, he was

1 feeling frozen and paralyzed. He was afraid of his
2 professional life. He asked her, "What should I do?"
3 In the June 2nd, 2007, visit, he mentions to Ms. Reed
4 about no backstop financially. Even though he was making a
5 million dollars a year, he was anxious about his finances.
6 And then those next two visits in June, again,
7 notations about needing to contain his anxiety, trying to step
8 out of the passive role. I think what Ms. Reed was doing
9 there was to get him to try to take control over some of the
10 things that were happening in his life as opposed to letting
11 them happen to him.
12 But the consistent thing here is anxiety about work,
13 worries that he wouldn't be able to function at the same level
14 as the Reed Smith attorneys, that he didn't have a background
15 as an international lawyer. And we'll see later that this
16 repeats itself in 2010.
17 By the way, he's not on any medication, either,
18 during this time.
19 Q. Did Ms. Reed explore what kind of relationship Mr. Dolin
20 had with his own family, his family of origin?
21 A. Yes.
22 Q. And what did -- what did that reveal?
23 A. Well, he was disconnected, sort of estranged from his
24 brother. I think he hadn't spoken to his brother in over
25 20 years. And he also was somewhat estranged from his mother.

1 Q. In June 2007, for how many months had Mr. Dolin been
2 reporting fears and anxiety to Ms. Reed?
3 A. By June -- so it was from February to June, so it was
4 about five months.
5 Q. Is there any significance to you that Mr. Dolin had been
6 experiencing these fears and anxieties for this period of
7 time?
8 A. Yes. It shows that it's a consistent, ongoing problem,
9 and it's in the context of the big merger with Reed Smith.
10 Q. Now, you mentioned no medicine. Was Mr. Dolin prescribed
11 medication to treat his anxiety in 2007?
12 A. Yes, he was.
13 Q. What medication?
14 A. Sertraline.
15 Q. And sertraline is the generic for what drug?
16 A. Zoloft.
17 Q. Is Zoloft or sertraline the same class of medicines as
18 Paxil or paroxetine?
19 A. Yes.
20 Q. Did you assist us in preparing a graphic illustrating for
21 how long Mr. Dolin took the sertraline?
22 A. I did. It's easier to see up on a picture.
23 MR. BAYMAN: Your Honor, I'd move at this point for
24 permission to publish Defense Exhibit --
25 MR. RAPOPORT: No objection.

1 MR. BAYMAN: -- 7038-5.
2 MR. RAPOPORT: That was no objection.
3 THE COURT: Proceed.
4 BY MR. BAYMAN:
5 Q. When did Dr. Sachman first prescribe sertraline?
6 A. On June 22nd, 2007.
7 Q. And for how long did Mr. Dolin continue to take
8 sertraline?
9 A. Well, he took it all the way into October of 2009, and
10 there are some gaps here where he was off it; but he took it
11 all the way until October 2009, about a year, year-and-a-half.
12 Q. Well, June 2007 to October --
13 A. I'm sorry, actually two years.
14 Q. Two years?
15 A. Two years. Two-and-a-half -- two-and-a-quarter years.
16 Q. And how many days' worth of sertraline was this?
17 A. It was approximately 600 days.
18 Q. What dose did he -- of sertraline did Mr. Dolin take?
19 A. He started off on 50 milligrams per day, and then it was
20 increased to 100 milligrams a day.
21 Q. Is there any evidence from the medical records that
22 Mr. Dolin had akathisia from taking sertraline during 2007
23 to 2009?
24 A. None.
25 Q. Did he report any side effects from the sertraline to

1 Dr. Sachman or any other healthcare professional from June
2 2007 to 2009?
3 A. No.
4 Q. Now, you mentioned that there were some gaps in his
5 sertraline prescriptions. Is that significant to you?
6 A. Yes, and same reasons as in 2005 with the paroxetine. He
7 wasn't always compliant with taking the sertraline. You're
8 supposed to take it every day, and he had a lot of times when
9 he was starting and stopping and restarting the medication.
10 Q. Now, after Mr. Dolin started taking the sertraline in
11 June of 2007, did he continue to see Ms. Reed for therapy?
12 A. Yes.
13 Q. Did you prepare a graphic regarding -- timeline graphic
14 regarding Mr. Dolin's next several visits to Ms. Reed that
15 summarizes what you felt were significant?
16 A. I did.
17 MR. BAYMAN: I'd like permission, your Honor, to
18 publish DX 7038-6.
19 MR. RAPOPORT: No objection.
20 BY MR. BAYMAN:
21 Q. Okay. Walk us through this graphical timeline and tell us
22 what you found significant in the period from June 2007 to
23 November 2007.
24 A. Well, I won't walk through every visit, but there's some
25 general things I think you can say about this. But one is

1 that the general trade is that he's getting better. He's on
2 the sertraline. Things are going better.
3 You look at the August 25th visit, he's feeling
4 better. September 15, 2007, visit, perception is reality.
5 October 7th, Stu doing well. November 10th, 2007, he
6 recognized he can survive hell.
7 So, the general trend is improvement. However,
8 there's a couple of things I would want to point out that I
9 think are important.
10 On August 9th, 2007, he tells Ms. Reed that he
11 felt -- in his old firm, he felt he was his own boss, but now
12 he isn't his own boss. For some reason, she put that in caps.
13 And that is true, right? He was a big fish in his --
14 Sachnoff & Weaver. He was on the leadership group. At Reed
15 Smith, he had a boss, and his boss had a boss; and it was a
16 different atmosphere. It's interesting that he mentioned
17 that.
18 The other thing I think that's very important is on
19 September 15th, 2007, when Ms. Reed writes, "How fragile his
20 psychological balance is." Now, this is a period of time when
21 he was doing better, but I think what she means by that is it
22 wouldn't take -- doesn't take much to tip him into feeling
23 really bad. It often was related to the external events such
24 as work, particularly work.
25 I mean, in fact, some of the reason he may also have

1 been doing better here is that things are better at work also,
2 right? If you look at the October 14th, 2007, "He feels he's
3 getting respect from others at work. Feeling good about
4 work."
5 A lot of, you know, his psychological, his fragile
6 psychological balance had to do with things that were
7 happening, but what the word "fragile" means is that it didn't
8 take much to tip him back into anxiety.
9 Q. Is there any significance to the fact that despite doing
10 better there later in 2007, that he had been expressing
11 anxiety and some fears for at least six months to Mrs. Read?
12 A. Yes. I mean, this has been going on for quite some time.
13 He's doing somewhat here in this time period, and he's also on
14 the sertraline; but this has been an ongoing problem,
15 obviously.
16 Q. Now, you mentioned at some point he changed -- his
17 sertraline does was changed in the fall of 2007. When was
18 that?
19 A. It was in the middle of October of 2007.
20 Q. Was that an increase or a decrease?
21 A. Increase.
22 Q. Do we know why his dose was increased then?
23 A. No.
24 Q. How did Mr. Dolin do in the fall of 2007 after the dose --
25 the sertraline dose was increased?

1 A. Well, you can see from Ms. Reed's notes that in October of
2 2007, you know, he's feeling better, seeing his own leadership
3 skills more clearly. And in the November 10th, 2007, visit,
4 he says he recognized he can survive hell. Looking at the
5 benefits of what he went through. So, he's more positive in
6 those visits after the dose increase of sertraline.
7 Q. Since he began the sertraline in June of 2007, did
8 Mr. Dolin report to anyone that he was having problems or
9 side effects on sertraline?
10 A. He did not.
11 Q. Do the medical records support that sertraline effectively
12 treated Mr. Dolin's anxieties?
13 A. They do.
14 Q. Now, the jury has heard that Mr. Dolin reported suicidal
15 thoughts to Ms. Reed on December 1, 2007.
16 A. Yes.
17 Q. Are you familiar with the notes from that visit?
18 A. I am.
19 Q. Turn, if you would, to Tab 4 in your book, which is Joint
20 Exhibit 9. Have you got that?
21 A. I have Tab 4, yes.
22 Q. Are those the notes from Sydney Reed, the actual notes?
23 A. Yes.
24 MR. BAYMAN: Your Honor, at this point, I'd like to
25 publish from Joint Exhibit 9, page 9-003.

1 THE COURT: You may proceed.
2 BY MR. BAYMAN:
3 Q. All right. What note is this?
4 A. So, this is Sydney Reed's note from December 1st, 2007.
5 Q. And how did this compare -- this visit compare to prior
6 visits in the fall of 2007?
7 A. Well, the prior visits, he was doing better, and in this
8 one, he says he's depressed and down and has suicidal
9 thoughts.
10 Q. Tell us what else is significant.
11 A. So, he -- Mr. Dolin tells this to Ms. Reed, and Ms. Reed
12 notes that she examined them carefully; and Ms. Reed said that
13 the suicidal thoughts appeared to be related to wanting to
14 escape the pressure of work. Now, we saw that before, escape
15 the pressure of work, when he first came to Ms. Reed.
16 He had no plan, and he calmed down with the talking
17 about the situation at work and how he could handle it. And
18 he was looking forward to seeing his kids for the holiday.
19 Q. Based on your review of the testimony and the other
20 materials in the case, was year end a stressful time for
21 Mr. Dolin?
22 A. Yes, year end at the Reed Smith law firm was a very
23 stressful time. They were -- the lawyers were trying to
24 collect on all of their bills to finish out the year, and
25 those kinds of metrics would have implications for their

1 salaries and other things the following year.
2 Q. Did you find this report of suicidal thoughts surprising,
3 given how well Mr. Dolin appeared to be doing in prior visits
4 that fall?
5 A. Not really. I mean, Ms. Reed had already noted that
6 Mr. Dolin, before this, was fragile, that he was
7 psychologically fragile. It wouldn't take much to stress him
8 out. And so, no, I'm not that surprising -- it's not that
9 surprising.
10 And he was able -- it's not unusual for patients who
11 suffer from anxiety and depression to have suicidal thoughts,
12 I mean, so -- and she was able to improve the situation by
13 having him talk about the -- about the situation.
14 And Ms. Reed herself says it's work-related.
15 Q. Did Ms. Reed inform either Dr. Sachman or Mrs. Dolin about
16 those suicidal thoughts that Mr. Dolin expressed on
17 December 1, 2007?
18 A. She did not.
19 Q. Did Mr. Dolin tell either Dr. Sachman or Mrs. Dolin about
20 his suicidal thoughts?
21 A. No.
22 THE COURT: All right. We'll take a break now.
23 MR. BAYMAN: Thank you, your Honor.
24 (Jury exits courtroom.)
25

1 (Recess had.)
2 (Change of Reporters -- Volume 17-C.)
3 (Proceedings heard in open court. Jury in.)
4 THE COURT: All right. Thank you very much, ladies
5 and gentlemen. Please be seated. We'll resume.
6 You may proceed, sir.
7 MR. BAYMAN: Thank you, your Honor.
8 BY MR. BAYMAN:
9 Q. Before the break, Dr. Rothschild, we talked about
10 Mr. Dolin's expression of suicidal thoughts to Ms. Reed on
11 December 1, 2007. Do we know for how long Mr. Dolin's
12 suicidal thoughts continued?
13 A. Well, we know that he saw Dr. Sachman two weeks later, so
14 December 15th, 2007, and by that point, they were gone.
15 Q. And what was -- what was he telling Ms. Reed shortly after
16 the first of the year about how things were going at work?
17 A. Well, he saw Ms. Reed on January 12th, 2008, and things
18 were better. Things were going better at work. And, you
19 know, if you look at Ms. Reed's testimony, her deposition, she
20 even said that when the pressures at work resolved, the
21 suicidal thinking went away.
22 Q. Now, I ask you to assume that Dr. Glenmullen attributed
23 Mr. Dolin's suicidal thinking in December 2007 to his
24 increased dose of sertraline in mid-October, some six weeks
25 earlier. Do you agree with Dr. Glenmullen?

1 A. No.
2 Q. Why not?
3 A. Multiple reasons. There's no scientific evidence that
4 sertraline causes suicide. He only had suicidal ideation, he
5 reported, on that one day. Ms. Reed, who is his therapist,
6 said it was related to the work stresses. That was her --
7 she's seeing Mr. Dolin, and that was her conclusion. And then
8 when Ms. Reed also concluded that when the work stresses
9 resolved, the suicidal thinking that Mr. Dolin had went away.
10 Q. How did -- what did Mr. Dolin report to Ms. Reed about how
11 he was feeling in November of 2007 after the dose increase?
12 A. He was feeling better.
13 Q. Is there something special about the six-week mark that
14 Dr. Glenmullen has referred to?
15 A. No.
16 Q. In your opinion, if the increased sertraline dosage were,
17 in fact, affecting Mr. Dolin in some way, would you expect him
18 to have reported problems prior to six weeks on the medicine?
19 A. Yes, prior to six weeks and then afterwards. I mean, he
20 was on sertraline for a long period of time.
21 Q. And did he ever report any problems on sertraline during
22 this time in 2007-2008?
23 A. No, he didn't report any problems. I mean, this one visit
24 where he says he has suicidal ideation, it appeared to be
25 related to the work stresses. That's what his therapist

1 thought. And when the work stresses resolved, he was no
2 longer having suicidal ideation.
3 Q. Did you help prepare a graphic addressing and summarizing
4 Mr. Dolin's next visits to Ms. Reed in 2008?
5 A. I did.
6 MR. BAYMAN: Your Honor, permission to publish DX
7 7038-7.
8 THE COURT: Proceed.
9 MR. RAPOPORT: No objection.
10 THE COURT: Pardon me?
11 MR. RAPOPORT: No objection.
12 THE COURT: Proceed.
13 BY MR. BAYMAN:
14 Q. As a psychiatrist who's treated patients with anxiety and
15 depression, what did you consider significant from Mr. Dolin's
16 visits to Ms. Reed in 2008?
17 A. Well, as we were just alluding to the January 12th, 2008,
18 he was able to laugh and be more relaxed and at the same time
19 reports that he's doing well financially at the firm.
20 February 9th, he's back to his old self, billed $4 million.
21 Experiences change in a positive way.
22 So he's doing better in 2008 and work is going
23 better. And this continued in March and April. And then when
24 we get to June 2008, he tells Ms. Reed that he's better and he
25 feels ready to terminate the therapy.

1 Q. At any of these visits in 2008, was there any mention of
2 Mr. Dolin's experiencing suicidal thoughts?
3 A. No.
4 Q. Was he continuing to take sertraline on and off during
5 this period of time in 2008?
6 A. Yes. He was on sertraline, for the most part, through all
7 that period of time.
8 Q. And the -- whose decision was it to stop the therapy with
9 Ms. Reed in June of 2008?
10 A. Mr. Dolin's.
11 Q. Now, did Mr. Dolin's anxieties about work come to the
12 surface again at some point in 2010?
13 A. They did.
14 Q. Would you tell us about that?
15 A. Well, in 2010, some of his old fears and anxieties that he
16 had had in the 2007 period returned, but this time there were
17 some real things happening to Mr. Dolin at work, bad things
18 that played into his feelings of inferiority, inadequacy, and
19 in some ways his nightmare of being inadequate was actually
20 coming true.
21 Q. Now, the jury has seen some documents produced by Reed
22 Smith. Did you assist in preparing a graphic summarizing the
23 work-related stresses that you believe Mr. Dolin was
24 experiencing in 2010 so that we don't have to go through the
25 documents individually?

1 A. Yes. This is a summary. This is a brief summary.
2 Q. It would be helpful to show your summary?
3 A. Yes.
4 MR. BAYMAN: Your Honor, permission to publish at
5 this time defense Exhibit 7038-8.
6 MR. RAPOPORT: No objection.
7 THE COURT: Proceed.
8 MR. BAYMAN: Let's put that up.
9 BY MR. BAYMAN:
10 Q. Okay. Please summarize the work stresses influencing
11 Mr. Dolin in 20' --
12 A. This is a summary.
13 Q. Okay.
14 A. 2009, as we'll see, Mr. Dolin described as his most
15 challenging year ever in his career. And he wrote in his
16 evaluation -- he wrote that in his evaluation of 2009, that
17 2010, he had to focus on improving but what happened was, in
18 2010, he had harsh criticisms from his colleagues on his role
19 as a practice group leader on his evaluations.
20 His compensation was decreased. And Mr. Dolin
21 appealed it. And in his own words, he described it as a
22 seismic shock. Those are Mr. Dolin's words. He was removed
23 as the sole leader of the practice group at Reed Smith.
24 I talked about this, but he had serious issues with
25 two very important clients. That was occurring around -- just

1 before he committed suicide. And his therapist, Ms. Reed,
2 wrote about the fear that she had described in 2007 before he
3 was ever on -- when he wasn't on medications, his
4 psychological fear loop had returned. And the fear loop is
5 this feelings of inadequacy and inferiority, that he was
6 incompetent, that that had returned.
7 Q. Now, you said that was a summary. I want to ask you about
8 a couple of these things. Did you review his self-evaluation
9 in 2010 for his performance in the year 2009?
10 A. I did.
11 MR. BAYMAN: Would you turn to Tab 5 in your book?
12 That's defense Exhibit 3037, your Honor. It's
13 already in evidence.
14 THE COURT: You may proceed.
15 MR. BAYMAN: May I have permission to publish?
16 THE COURT: Yes.
17 BY MR. BAYMAN:
18 Q. Is this Mr. Dolin's self-evaluation?
19 A. Yes.
20 Q. What were the comments in that self-evaluation that you
21 found to be of significance?
22 A. Well, right at the beginning, it says, "2009 has without a
23 doubt been my most challenging year ever in my professional
24 career." The economy, it was during the recession, the great
25 recession. "The economy played havoc with the practices of so

1 many of our lawyers in corporate and securities including my
2 own." So he was hoping to do better in 2010.
3 Q. Why did you consider it significant that Mr. Dolin found
4 2009 to be the most challenging year of his professional
5 career?
6 A. Well, I mean, he -- he was the leader of this group, and
7 the group didn't do well financially. They were way below
8 their targets. And he personally as an attorney was below his
9 targets.
10 MR. BAYMAN: You can take that down.
11 BY MR. BAYMAN:
12 Q. You mentioned he received some harsh criticisms from
13 colleagues. That was on one of your lists of stresses.
14 Criticisms from whom?
15 A. These were other partners at the law firm or equity
16 partners. It was colleagues.
17 Q. The jury has seen some of these evaluations. Just tell us
18 which comments were significant to you for your opinions in
19 this case.
20 A. Well, there were several. "Middle market lawyer from a
21 middle market firm leads global C & S group, question mark.
22 Enough said." "Utter lack of knowledge of C & S practice at
23 Reed Smith. Plays favorites. Arrogant. Non-responsive.
24 Deceitful. That enough?"
25 "Not motivational. Doesn't know the people in the

1 group. Not a particularly solid group leader." And there's
2 some others.
3 Q. Okay.
4 A. "He's a terrible PGL." I guess that's practice group
5 leader. There are a lot of very harsh comments made.
6 Q. Do -- can you tell whether if it was one person or more
7 than one who was being critical of Mr. Dolin?
8 A. Well, I can't tell this from the comments per se how many
9 people it was, but if you look at, before they write the
10 comments, they -- there's one of those rankings: Strongly
11 agree, agree, neutral, strong -- disagree, strongly disagree.
12 And you can count the number of people who answered those
13 questions.
14 MR. BAYMAN: Let's stop you for a second.
15 Your Honor, permission to publish DX 3055 which is
16 already admitted.
17 THE COURT: Proceed.
18 MR. BAYMAN: Okay. Go ahead and enlarge that.
19 The jury has seen the -- can you go back to the first
20 page?
21 The jury has seen the -- can you enlarge that?
22 BY MR. BAYMAN:
23 Q. The jury has seen the first page that has the evaluations
24 and comments, but the jury has not seen the page that you
25 mentioned. Could you talk about that?

1 And let's pull that up.
2 A. Well, it's over -- the page is indicated that about 20
3 people, 20 people filled this out. If we look at, for
4 example, marketing, if you add up all those numbers -- well,
5 it's actually added for you on the bottom. It's 20 people.
6 I mean, you can see in some of these, like, for
7 example, marketing, four strongly disagreed, seven somewhat
8 disagreed that he was good at marketing, so seven out of 20
9 were negative. Knowledge/awareness, five out of 20 were
10 negative.
11 So that gives us a sense of how many people filled
12 out the -- filled out the evaluation. It makes you think it's
13 more than one person who is actually writing these comments
14 that I just read a moment ago.
15 Q. In your opinion as a psychiatrist who's treated patients
16 with anxiety and depression, what effect, if any, would
17 comments and writings like this have on Mr. Dolin given his
18 work-related stress?
19 A. Well, they would be very hurtful. And you've got to
20 remember, Mr. Dolin was already feeling inadequate and
21 inferior, he wasn't up to the task at Reed Smith. That was
22 his inner fear. But now he's getting feedback, negative
23 feedback that his -- unfortunately, I think confirming for him
24 what he feared, that he wasn't competent enough to work at
25 Reed Smith.

1 Q. And did you see Mr. Iino's testimony about whether these
2 results were shared with Mr. Dolin?
3 A. Yes. I saw Mr. Iino's testimony, and Mr. Dolin was --
4 actually, Mr. Dolin emailed Mr. Iino about them.
5 Q. Does it matter to your opinion whether these criticisms
6 were fair or even true?
7 A. No. I mean, it doesn't matter because Mr. Dolin -- it's
8 Mr. Dolin's perception. And Mr. Dolin is the one getting the
9 comments. And again, he's -- already has these feelings of
10 inadequacy and inferiority, and they had to have been very
11 hurtful to him, true or not.
12 Q. Does it matter to your opinion whether these criticisms
13 reflected the views of a majority of Mr. Dolin's colleagues?
14 A. No. It's a significant minority but, you know, it's quite
15 a number. It's more than one person. It's several, seven, I
16 think.
17 Q. Why does it matter that a majority of the people may have
18 given him favorable feedback?
19 A. Because when someone is feeling inferior and inadequate
20 and has these fears longstanding, Mr. Dolin's case going back
21 many, many years, when this type of thing happens, it can be
22 very upsetting to them. And this is not the only thing. I
23 mean, there were other things that were happening, too, which
24 we'll talk about. They have got to have really upset
25 Mr. Dolin and made him worry that his fears that he was not

1 competent enough to work at Reed Smith would -- were coming
2 true.
3 Q. Did you review Mr. Dolin's practice group leader
4 evaluations for the two previous years when he served as
5 co-leader of the practice group?
6 A. Yes.
7 Q. Was Mr. Dolin evaluated by as many people in the two
8 previous years?
9 A. No.
10 Q. Was there anything -- during the time when he was the
11 co-head of the practice group, was there anything negative
12 like the feedback that we just saw and you talked about that
13 he got in 2009?
14 A. No, not when he was co-leader with Mr. Iino. It was when
15 he was the sole leader that he got all these negative comments.
16 Q. And did he get more negative comments from more people?
17 A. Yes.
18 Q. Was this -- was this change something -- this difference
19 something that would be significant to you?
20 A. Yes. I mean, he hadn't gotten comments like this before.
21 I mean, they really go right to the heart of what Mr. Dolin's
22 fears were. "Middle market lawyer from middle market firm,"
23 that refers to his old firm, Sachnoff Weaver, "leads global C
24 & S group, question mark. Enough said."
25 I mean, this is exactly what Mr. Dolin was afraid of

1 and fearful when that merger happened back in '08, and now
2 people are actually putting it in writing for him to read.
3 Q. Now, you mentioned Mr. Dolin's compensation was reduced in
4 2010.
5 A. Yes.
6 Q. To your knowledge, was that the first time that Mr. Dolin
7 ever had his budget compensation reduced?
8 A. Yes.
9 Q. In your opinion as a psychiatrist who treats patients with
10 anxiety, depression, what effect, if any, would a reduction in
11 compensation have had on Mr. Dolin?
12 A. Well, it would have been -- had a negative impact on him.
13 It's still a lot of money. It's more money than, you know,
14 most people make, but it's the perception, it's a message from
15 the firm that, "You're not" -- you know, "you're not doing
16 what we -- meeting our standard."
17 And the other thing that's occurred at this law firm
18 is, everybody's compensation could be seen by other people,
19 you know, amongst the equity partners. Everybody is -- it
20 wasn't a secret. And, you know, if you're working in a law
21 firm, I think you know if someone's compensation is reduced,
22 it's a message that they didn't do what they were supposed to
23 do, whether it was the number of billable hours or the
24 business they brought in. So this is another thing that
25 was -- got to have had a major impact on Mr. Dolin's already

1 underlying insecurities.
2 Q. Now, you understand Mr. -- Mr. Dolin had said to Ms. Reed
3 he was worried about being fired from the law firm.
4 A. Right.
5 Q. You understand he was not about to be fired from the law
6 firm?
7 A. I understand that, sure. It's his perception. It's his
8 perception of what was going on that, you know, he probably
9 believed at some point that he might be fired given all these
10 things that were happening, but this is a fear he had had for
11 years and years and years.
12 And unfortunately, in 2010, it was actually being
13 realized through public publishing of his decreased
14 compensation, from these comments, and some other things we're
15 going to talk about.
16 Q. Did you have a chance to review his memo appealing the
17 compensation denial?
18 A. I did.
19 Q. Was that significant to you as a psychiatrist?
20 A. Yes. I mean, I think we should look at it. And there's
21 some things that he said in the memo that I think are
22 revealing as how much of an impact this was having on
23 Mr. Dolin, and then the fact that it was denied upon review
24 was another -- you know, another blow to him.
25 MR. BAYMAN: Your Honor, at this point, I'd ask

1 permission to publish DX 3057 which is already in evidence.
2 THE COURT: Proceed.
3 MR. RAPOPORT: Wait. I'm sorry. Which tab is this?
4 MR. BAYMAN: Tab 16.
5 MR. RAPOPORT: No objection.
6 MR. BAYMAN: Thank you.
7 BY MR. BAYMAN:
8 Q. All right. Tell us what you found significant from his
9 compensation -- memo appealing his compensation and the
10 removing of the band.
11 A. Well, as I mentioned on my summary slide, Mr. Dolin says
12 that this is a seismic shock that he learned that "the value
13 that the firm placed on my efforts was a $75,000 bonus," which
14 they had given him, "plus the lowering of my compensation by
15 one band." And Mr. Dolin's own words says it's a seismic
16 shock.
17 In the beginning of the memo to the senior management
18 team, he talks about the fact that this is the first time he's
19 ever appealed a compensation decision pertaining to me -- to
20 him.
21 Q. Was his appeal successful?
22 A. No. The appeal was denied.
23 Q. Now, the jury heard from Mr. Lovallo that Mr. Dolin
24 appealed the moving of his compensation band and although that
25 wasn't successful, he got a $75,000 bonus. From your review

1 of this document, is that sequence of events correct?
2 MR. RAPOPORT: Objection to the mischaracterization
3 of Mr. Lovallo's testimony.
4 THE COURT: Well, are you referring to some
5 transcript statement? If so --
6 MR. RAPOPORT: That he said that the appeal was
7 successful, not what Mr. Bayman just represented, partially
8 successful because of the bonus.
9 MR. BAYMAN: Okay. Did -- I'll rephrase, your Honor.
10 BY MR. BAYMAN:
11 Q. Did Mr. Dolin know about the bonus before he was -- before
12 he appealed?
13 A. Yes.
14 Q. How do you know that?
15 A. It says right there that the shock, "the seismic shock I
16 felt to learn that the value that the firm placed on my
17 efforts was a $75,000 bonus." He was upset that it wasn't
18 more or he wasn't getting more compensation. He already knew
19 he got the $75,000 bonus.
20 Q. Was the $75,000 bonus given to him as a result of his
21 appeal?
22 A. No. He already had it, and then he was appealing.
23 Q. Thank you. Do you attribute any significance as a
24 psychiatrist and to your analysis in this case to the denial
25 of the appeal and how it impacted Mr. Dolin?

1 A. Yes. He gets knocked down twice on this issue. I mean,
2 he gets the compensation cut, and it's a seismic shock to him,
3 as he says. Then he appeals it and the appeal is denied. So
4 again, it would just be the senior management team is
5 confirming to Mr. Dolin that, "You deserve a compensation cut."
6 MR. BAYMAN: You can take that down.
7 BY MR. BAYMAN:
8 Q. You mentioned earlier that Mr. Dolin went from being the
9 sole leader of the corporate and securities group to being the
10 co-leader of the practice group. In your opinion as a
11 psychiatrist who's treated patients with anxiety and
12 depression, would his confidence have been shaken by the shift
13 from being the sole leader to a co-leader?
14 A. Yes, I think so. And the co-leader was a much younger
15 attorney named Paul Jaskot. And they made the younger co --
16 the younger Mr. Jaskot a co-leader with Mr. Dolin and, you
17 know, his -- the group was not doing well. I mean, it would
18 be clear that this was done because the group had not been
19 doing well.
20 And if you read the testimony of the people at Reed
21 Smith, particularly the man who made this decision, Mr. Iino,
22 the plan was actually to have Mr. Jaskot take over the whole
23 thing, and Mr. Dolin must have known that.
24 Q. And did -- after Mr. Dolin's death, did Mr. Jaskot take
25 over as the sole practice group leader?

1 A. Yes. And at the time of reading his deposition, I think
2 he still was the sole practice group leader.
3 Q. In your opinion as a psychiatrist, what effect, if any,
4 would this -- would you expect this change to have had on
5 Mr. Dolin?
6 A. Well, it must have been embarrassing. It must have been
7 another blow to his self-esteem; again, keeping in mind that
8 this was a man who always had insecurities about work, that he
9 was incompetent to work at a big international law firm. So
10 it's just -- you know, he has these fears, but now the reality
11 is actually happening. His fears are actually happening.
12 Q. Whose -- who did you say made the decision to make
13 Mr. Jaskot the co-leader?
14 A. Right. Well, I was just going to say, to answer your
15 question, the decision was made by Mr. Iino, but that's not
16 what Mr. Dolin told people.
17 Q. What did Mr. Dolin tell people?
18 A. I mean, he told Mrs. Dolin that it was his decision. He
19 told other people at the law firm that it was his idea to have
20 this co-leader person. But if you read Mr. Iino's testimony,
21 it was actually Mr. Iino's decision.
22 And again, I think that shows how -- I mean, he
23 couldn't even tell his wife about it. He was embarrassed by
24 the younger man being put with him as the co-leaders.
25 Q. The jury has heard Dr. Glenmullen testify that, in his

1 opinion, the stress level Mr. Dolin faced in 2007 and 2008 was
2 much greater than what Mr. Dolin faced in 2010. Based on what
3 we've gone through so far, do you agree with him?
4 A. No, no. It's backwards. The stresses in 2010 were much
5 greater, and we're going through them, were much greater than
6 in 2007-2008. The insecurities and the fears that Mr. Dolin
7 had were the same, but in 2010, there were real things
8 happening that were confirming for Mr. Dolin that his fears
9 were coming true, that he was not up to snuff of working at
10 Reed Smith.
11 Q. Were his fears actually coming true, or were they coming
12 true in his mind?
13 A. Well, some real things were happening. I mean, we talked
14 about the harsh criticisms, the compensation decrease which to
15 him was a seismic shock, the co- -- the young co-leader being
16 put together with him. I mean, the fears were in his mind,
17 but these things were actually happening.
18 Q. Now, Dr. Glenmullen testified that Mr. Dolin was turning
19 his work stress around in 2010 because he already had billed
20 more than the entire year 2009 and 2010. Do you agree with
21 that?
22 A. No.
23 Q. Did you assist us in preparing a graphic that shows
24 Mr. Dolin's billable hours based on the records you reviewed
25 from Reed Smith for each of the first six months of 2010?

1 A. Yes. There's a -- I made a chart of his billable hours.
2 Q. Would it be helpful to display that to illustrate your
3 opinion?
4 A. Yes.
5 MR. BAYMAN: Your Honor, I move for permission to
6 publish defense Exhibit 7038-9.
7 MR. RAPOPORT: What tab are we?
8 MR. BAYMAN: Oh, sorry. It's behind Tab 20. It's
9 just the next one in the sequence.
10 MR. RAPOPORT: No objection. It's 19?
11 MR. BAYMAN: Yes -- no, it's 9.
12 MR. RAPOPORT: 9.
13 MR. BAYMAN: 7038-9.
14 MR. RAPOPORT: No objection to 9.
15 BY MR. BAYMAN:
16 Q. What did your review of Mr. Dolin's billable hours reveal
17 about his performance, billable hour performance in 2010?
18 A. So his total billable hours for the first six months was
19 460. His target was 1400 hours per year. So at this rate, he
20 would be at 920, and he would be way below target.
21 Q. And how is his performance the prior year in billable
22 hours?
23 A. In 2009, it wasn't good either. It was below, way below
24 target, also.
25 Q. It was 733, right?

1 A. Yeah. And he had hoped to do better in 2010. But his
2 target at the firm was 1400.
3 Q. Beyond hours alone, in your opinion, reviewing the
4 materials in this case, was Mr. Dolin turning it around in
5 2010?
6 A. No, no, not at all.
7 Q. Now, when was Mr. Dolin informed of the decision to name
8 Paul Jaskot as the co-leader of the group?
9 A. I believe Mr. Iino testified that he told him on April
10 30th, 2010.
11 Q. And did Mr. Dolin return to see Sydney Reed in May of 2020
12 to discuss stresses at work?
13 A. He did.
14 Q. Did you prepare another graphic in the timeline that
15 summarizes what you felt was significant about Mr. Dolin's
16 next few visits to Ms. Reed?
17 A. I did.
18 MR. BAYMAN: Your Honor, at this point, we would move
19 for permission to publish DX 7038-10 which is the next entry
20 in the timeline.
21 THE COURT: You may proceed.
22 MR. RAPOPORT: No objection. And to expedite this,
23 we're not going to object to the rest of these under this tab
24 either, so you can skip all --
25 MR. BAYMAN: Thank you.

1 MR. RAPOPORT: -- the fancy stuff.
2 MR. BAYMAN: Thank you. Mr. Wisner is not here.
3 BY MR. BAYMAN:
4 Q. Were some of the concerns -- what were some of the
5 concerns Mr. Dolin related to Ms. Reed that were significant
6 to you as a psychiatrist for the visits in -- on May 20 and
7 June 3, 2010?
8 A. Well, again, he's back talking about issues at work and
9 the work-related stress. And he was looking at his position
10 at the firm, does he want to continue as head of the
11 leadership group although he had already been told that he was
12 going to be -- have a co-leader, Mr. Jaskot, but he was
13 wondering whether he even wanted to continue working there.
14 And he was feeling pressure of no backstop. I think that
15 refers to, he's used that term before, financial backstop. He
16 was feeling less connected.
17 The June 3rd visit, Ms. Reed describes him as highly
18 anxious, and the old fear loop has been re-triggered. Now,
19 that old fear loop is the anxieties and insecurities he has
20 about work, that he didn't go to Harvard or Yale law school,
21 that he wasn't going to be able to hack it at an international
22 law firm. That's what they describe as the fear loop.
23 But the difference this time is that real things were
24 happening: The criticisms, the cutting his compensation,
25 younger Jaskot being put in as the co-leader. And his fears

1 were -- his fears were coming to reality. And he told her he
2 was not enjoying being the practice group leader, and he was
3 confused about his job, whether he should stay there or
4 whether he should leave.
5 Q. So did you find it significant that Reed -- Ms. Reed
6 compared 2010 to 2007?
7 A. Yes. I mean, the psychological fear loop that he had,
8 that was the same, but the difference was now there were real
9 bad things happening to him at work to his sense of
10 self-esteem and being competent.
11 Q. And were these things being -- these fears being externally
12 validated?
13 A. Yes.
14 Q. During this period of time when Mr. Dolin was highly
15 anxious, was he taking any medication to treat his anxiety?
16 A. No.
17 Q. I want to turn -- publish, if you will, DX 7038-11, show
18 this graphic that you've helped us prepare. Explain what
19 you're trying to show on this graphic.
20 A. Well, this is kind of like what I was alluding to a moment
21 ago. I mean, we have the 2007 notes where he's anxious about
22 the upcoming merger with the law -- international law firm, he
23 didn't feel qualified, extreme negative thinking, great fears
24 of being able to do the job, whether he was competent to do
25 the job. He identified this as the fear loop.

1 And if we go to 2010 which is in the red, she writes
2 the old fear loop has been re-triggered. And we talked about
3 these comments. But this particular comment, the "middle
4 market lawyer from a middle market firm leads global C & S
5 group, enough said," I mean, that must have really hit
6 Mr. Dolin hard.
7 Q. The jury has heard Dr. Glenmullen testify that the old
8 fear loop returning was nothing new. Do you agree with
9 Dr. Glenmullen?
10 A. Well, no. The fears were the same as 2007, but what was
11 different was all these external confirmations at work that
12 were becoming a reality, that his fears were becoming a
13 reality.
14 Q. Now, did Mr. Dolin receive treatment from Dr. Sachman in
15 June of 2010?
16 A. Yes.
17 Q. What treatment?
18 A. Well, Dr. Sachman prescribed sertraline again for Mr. Dolin
19 in June of 2010.
20 Q. Do his records indicate the reason he prescribed
21 sertraline for Mr. Dolin in June of 2010?
22 A. I think it was work -- he said work-related anxiety.
23 Q. What dosage was prescribed?
24 A. Initially, it was 25 milligrams, and then it was increased
25 to 50 milligrams.

1 Q. How did this compare to the dose of sertraline that
2 Mr. Dolin had been taking back in late 2009?
3 A. It was a lower dose.
4 Q. What was he taking back then?
5 A. Back then, he started on 50 milligrams per day and was
6 raised to 100 milligrams per day. And for most of the time,
7 he was on 100 milligrams per day, so this was less in 2010.
8 Q. Is 25 milligrams a therapeutic dose of sertraline based on
9 your experience?
10 A. It is not.
11 Q. What is the minimum recommended therapeutic dose for
12 sertraline?
13 A. 50 milligrams. The dose range is actually 50 to 200
14 milligrams per day.
15 Q. How did Mr. Dolin do on sertraline in June of 2010?
16 A. He didn't take it very long. He called Dr. Sachman and
17 said that he having some non-specific complaints, nausea, I
18 think was one of them, on the sertraline, and he just stopped
19 it and told Dr. Sachman he had stopped it.
20 Q. Now, do we know from Dr. Sachman's records or testimony
21 whether the problems Mr. Dolin reported were related to the
22 sertraline?
23 A. We don't. I mean, he was on other medications, too, at
24 the time.
25 Q. Does the fact that Mr. Dolin called Dr. Sachman to report

1 that he wasn't feeling well tell you anything about
2 Mr. Dolin's willingness to tell Dr. Sachman when he felt a
3 medication wasn't working or complain about a side effect?
4 A. Yes. Mr. Dolin was having a side effect on the
5 medication, and he called Dr. Sachman to tell him.
6 Q. And do we know what side effect it was?
7 A. I think it was kind of nonspecific. I think it might have
8 been nausea.
9 Q. Why then would Mr. -- or would Dr. Sachman switch Mr. Dolin
10 to paroxetine?
11 A. Well, the records indicate that he switched back to
12 paroxetine because he remembered, Dr. Sachman remembered, that
13 he -- that Mr. Dolin had done well on paroxetine in the past,
14 so they decided to go back to that.
15 Q. Now, the jury has heard Dr. Glenmullen testify that our
16 physiology changes as we age and we become more vulnerable or
17 more sensitive to SSRI medications and that Mr. Dolin was more
18 vulnerable in 2010 than he'd been in 2009. Do you agree with
19 that?
20 A. No. I mean, it is true that the metabolism of medications
21 of a 25-year-old is different from a 75-year-old, but not one
22 year, no.
23 Q. Is there any scientific support that people become more
24 vulnerable or more sensitive to SSRIs?
25 A. No.

1 Q. Is there any suggestion in the medical records or the
2 testimony that Mr. Dolin was agitated or experienced akathisia
3 while briefly taking sertraline in June of 2010?
4 A. No.
5 Q. Now, did Mr. Dolin see Ms. Reed again after June 3rd, 2010?
6 A. Yes, he did.
7 Q. Why don't we turn to the next -- and put up 7038-12.
8 What from the June 22nd, 2010, timeline was
9 significant to you as a psychiatrist?
10 A. Well, this note shows the continued deterioration of
11 Mr. Dolin that had been occurring before this and was going to
12 continue after this. Convinced himself he can't do the work;
13 excuse to curl up in a corner; thinks he's pointed himself in
14 a corner; fear of failure puts him in a position of not even
15 trying; still feeling depressed; same complaints that he
16 expressed three years earlier.
17 He wanted -- if you remember, three years earlier, he
18 wanted to get up and run, escape the situation.
19 Q. Now, at some point in June of 2010, did Mr. Dolin start
20 receiving therapy from another mental healthcare provider
21 besides Ms. Reed?
22 A. Yes, a Dr. Salstrom.
23 Q. And when did he -- when did he start seeing Dr. Salstrom?
24 A. It was June 29th, 2010, so a week after this.
25 Q. What's the significance to you as a psychiatrist of the

1 fact that Mr. Dolin went to see another therapist in June of
2 2010?
3 A. Well, usually that's an indication that the person is not
4 doing well, that they're -- that somebody, either the patient
5 or the patient's family is saying, you know, "This isn't
6 working out. Let's -- maybe you should see somebody else."
7 And we know that the recommendation to see
8 Dr. Salstrom, that he got her name from Mrs. Dolin, so
9 Mrs. Dolin must have thought that he wasn't doing well.
10 That's usually the reason. What happened here, though, is he
11 ended up seeing two therapists at the same time, which is not
12 good.
13 Q. Had Mr. Dolin ever before, based on your review of the
14 records, found it necessary to seek therapist -- therapy from
15 more than one therapist?
16 A. No.
17 Q. What type of therapy did Dr. Salstrom practice?
18 A. So she practiced what's called cognitive behavioral
19 therapy, CBT for short. This is a form of therapy sort of
20 focusing on dealing with -- helping the person deal with
21 here-and-now-type problems as opposed to, you know, how your
22 parents raised you and your relationships with them growing
23 up. This is more of a here-and-now form of psychotherapy,
24 often with homework assignments that people are supposed to do
25 in between appointments.

1 Q. What's the goal of CBT, or cognitive behavioral therapy?
2 A. Well, usually people come in with complaints of anxiety or
3 depression. Those are the problems that are most helped by
4 cognitive behavioral therapy. And usually there's a
5 particular stress, stressful situation or situations that
6 people -- people are having trouble with. And the cognitive
7 therapy, cognitive behavioral therapy would focus on that
8 particular stress that the person was having. In the case of
9 Mr. Dolin, it was obviously work.
10 Q. How did her therapy method differ from Ms. Reed's therapy?
11 A. Well, Ms. Reed who was a social worker was more of a
12 talking therapy. I mean, I think she described herself as
13 what's called a Boeing family therapist. So they focus on the
14 family -- the therapy would focus on the family unit and the
15 relationships between the family. It was more of a -- if you
16 read her notes, it was really more of a sort of trying to make
17 him feel better, to cope, and looking at relationships and
18 things like that. It's a very different approach.
19 Q. Are you familiar with the -- what Dr. Salstrom advises her
20 patients when they start therapy from her which is otherwise
21 known as the informed consent?
22 A. Right. So she had an informed consent which she had the
23 person review and sign. Mr. Dolin did that. It talks about
24 the fact that one of the things that can happen in cognitive
25 behavior therapy is, as you know, you're forced to face the

1 things that fear you, is you might feel worse before you get
2 better.
3 Q. Would it be helpful to show that informed consent?
4 A. Yes.
5 MR. BAYMAN: Your Honor, permission to publish --
6 it's at Tab 7, Mr. Rapoport, Joint Exhibit -- it's from Joint
7 Exhibit 10 which is in evidence.
8 THE COURT: Proceed.
9 BY MR. BAYMAN:
10 Q. What did Dr. Salstrom advise her patients?
11 A. Well, she talks about that this psychotherapy can have
12 benefits and risks, often discussing unpleasant aspects of
13 your life. You may experience uncomfortable feelings like
14 sadness, guilt, anger, frustration, loneliness, and
15 helplessness.
16 And this is kind of what I just said, is that the
17 person can sometimes feel worse before they feel better
18 because they're forced to confront the things that are making
19 them anxious or depressed.
20 MR. RAPOPORT: Your Honor, a late objection here.
21 This therapy had not begun, so this is absolutely irrelevant.
22 MR. BAYMAN: Well, that's interesting. I'm going
23 to --
24 THE COURT: I beg your pardon?
25 MR. RAPOPORT: I'm sorry. You didn't hear. It was a

1 late objection to relevance because this particular therapy
2 had not begun.
3 THE COURT: Had not started?
4 MR. RAPOPORT: Had not started.
5 BY MR. BAYMAN:
6 Q. Was this the document that Mr. Dolin signs in the first
7 visit to begin therapy?
8 A. It's the first thing that was -- that was done, and then
9 she proceeded -- once he signed it, she then proceeded to
10 begin the cognitive behavior therapy.
11 Q. Now, to counsel's objection that --
12 THE COURT: Wait, wait. I don't care about counsel's
13 objection. How many times did she see him, do you know?
14 THE WITNESS: Three times.
15 THE COURT: Three times. Okay. Proceed.
16 BY MR. BAYMAN:
17 Q. The jury has heard Dr. Glenmullen say that Dr. Salstrom's
18 exposure treatment method wasn't the type of therapy that
19 Mr. Dolin was going to get and only exposure therapy increases
20 anxiety. Do you agree with that or not?
21 A. I don't agree. He was -- Mr. Dolin was getting the
22 therapy, and his exposure was every single day when he went in
23 to work.
24 Q. I think the example that Dr. Glenmullen did was, say,
25 someone who had a fear of elevator that -- elevators, you

1 would bring him to the elevator --
2 A. Right.
3 Q. -- have him look at the elevator, then have him get on
4 the -- I mean, can you explain how that differs from -- or
5 doesn't differ from what Dr. Salstrom was doing with
6 Mr. Dolin?
7 A. Sure. I've had patients with that exact problem. And
8 they spend lots of time walking up and down stairs, and they
9 get sick of walking up 25 floors and they say, "I need help
10 with my elevator phobia." And so that's exactly what you do.
11 You talk to them. You imagine them being in the elevator.
12 Then you go visit, have them go visit the elevator, maybe ride
13 it one floor. That's gradual exposure.
14 In the case of Mr. Dolin, it wasn't so simple as just
15 the elevator. His exposure -- he was getting exposures every
16 single day when he went in to work. And Dr. Salstrom had no
17 choice but to start the cognitive behavioral therapy right
18 away. He was getting exposed every single day. And her
19 records reflect, in my opinion, that she was, in fact, doing
20 that.
21 Q. So in your opinion, was she actually giving him therapy
22 the first and second and third visits?
23 A. Yes.
24 Q. Did Dr. Salstrom complete an intake form?
25 A. Yes.

1 Q. Did you prepare a graphic summarizing that intake form?
2 A. I did.
3 MR. BAYMAN: Okay. Permission to publish Joint
4 Exhibit -- it's from Joint Exhibit 10, your Honor, and it's DX
5 7038-13.
6 MR. RAPOPORT: Hang on.
7 No objection.
8 MR. BAYMAN: Thank you.
9 THE COURT: Are these all direct quotes?
10 MR. BAYMAN: These are, Dr. Rothschild --
11 THE COURT: They're all direct quotes from the
12 record?
13 MR. BAYMAN: Yes, sir.
14 THE COURT: Okay. Go ahead.
15 BY MR. BAYMAN:
16 Q. Tell us, what were some of Mr. Dolin's initial concerns
17 that were significant to you as a psychiatrist that he
18 reported on the intake form to Dr. Salstrom?
19 A. So there were all these things happening to him at work,
20 so it's not surprising that he says he's there to work on
21 anxiety at work that he's been having for the last month and a
22 half which would take us back to mid-May of 2010. He's
23 worried that he's going to make a mistake and something bad is
24 going to happen, he would be penniless and ability to support
25 his family. He was worried about his competence, didn't feel

1 clear in his mind, so he was having concentration problems.
2 He had lost weight. He had a decreased appetite, and
3 he had lost ten pounds' weight in the last month. He had
4 closed a big transaction and now he was not busy. And he's
5 stuck in worry, and he's not sleeping well.
6 And interestingly, Dr. Salstrom had a question that
7 she would ask the patients, "If I could do one thing for you,
8 if I had a magic wand and I could do one thing for you, what
9 would you like me to do?" It's a very interesting question in
10 what a patient would answer. And Mr. Dolin said, "No stress."
11 Q. Now, Mr. Dolin reported that he was not sleeping well. In
12 your experience, can that be a sign of a mental health issue?
13 A. Yes. That's commonly seen in people who suffer from
14 anxiety and also depression.
15 Q. You also mentioned weight loss. Based on your experience
16 as a psychiatrist, is the type of weight loss noted here the
17 kind where a patient is reporting actively trying to lose
18 weight for diet or health reasons?
19 A. Well, that would be different, but there's no indication
20 from the records that Mr. Dolin was doing that. What you have
21 here, though, is decreased appetite, and with that decreased
22 appetite with the weight loss, that's not -- that's not from
23 dieting. That's due to the -- we see that in depression and
24 anxiety.
25 Q. Mr. Dolin replace -- reported complaining of anxiety at

1 work for the last month and a half on that first visit. If we
2 go back a month and a half from June 29th, when would that
3 have started?
4 A. It would be around mid-May 2010.
5 Q. And what would have been going on in mid-May of 2010?
6 A. Well, he would have already been told by Mr. Iino that he
7 was going to add Mr. Jaskot as the co-practice leader. It
8 hadn't been announced -- it was about to be announced to --
9 within the firm. The public announcement, I think, came in
10 early July but, you know, he was dealing with all the things
11 we've already talked about.
12 Q. Was Mr. Dolin on any medication for his anxiety at the
13 time of this first visit on June 29th with Dr. Salstrom?
14 A. No.
15 MR. BAYMAN: Your Honor, at this point, permission to
16 publish the next entry in Dr. Rothschild's summary timeline,
17 DX 7038-14.
18 MR. RAPOPORT: No objection.
19 BY MR. BAYMAN:
20 Q. Let's go ahead and take a look at that, Doctor. What --
21 as a psychiatrist, what did you find significant about Dr. --
22 Mr. Dolin's first session with Dr. Salstrom?
23 A. Well --
24 THE COURT: Excuse me. Is this from Dr. Salstrom?
25 MR. BAYMAN: Yes, your Honor.

1 THE COURT: On June 29th?
2 MR. BAYMAN: Yes, sir.
3 THE COURT: Okay.
4 BY THE WITNESS:
5 A. So Mr. Dolin tells Dr. Salstrom about his longstanding
6 history of feelings of insecurity at work and we, of course,
7 knew that also from -- told the same thing to Ms. Reed.
8 Anxiety and worry occurred during major mergers and
9 responsibility changes in the past. No history of depression
10 or suicidal ideation or attempts, and he had many stresses at
11 work -- stressors at work and felt it was a chaotic
12 environment, so a lot of work-related complaints.
13 Q. Did Dr. Salstrom actually ask Mr. Dolin about whether he
14 had suicidal thoughts before?
15 A. She did ask him, yes, and he denied it.
16 Q. Now, Dr. Glenmullen has testified that Mr. Dolin may have
17 either forgotten about his December 2007 suicidal thoughts or
18 he didn't realize what he had on December 1, 2007, were
19 suicidal thoughts in the first place. Do you agree with that
20 explanation?
21 MR. RAPOPORT: I object, your Honor, to the loose
22 characterization.
23 THE COURT: Yes. If you're going to quote
24 Dr. Glenmullen, you've got to do it by transcript.
25 MR. BAYMAN: Okay.

1 THE COURT: Read the question and the answer.
2 MR. BAYMAN: Yes, sir.
3 THE COURT: Page?
4 MR. BAYMAN: 19' -- Page 1963.
5 MR. RAPOPORT: Date and session, please.
6 MR. BAYMAN: Oh, I'm sorry. It's March 29th. It's
7 the 10:00 a.m. session. It's at the bottom of 1963.
8 MR. RAPOPORT: We'll need lines.
9 MR. BAYMAN: Yes. I'll give it to you. I just need
10 to see where the question starts.
11 We can -- the question can start at Line 8, and it
12 would go from 1963 to 1964, Line 12.
13 MR. RAPOPORT: One moment.
14 MR. BAYMAN: Sure.
15 MR. RAPOPORT: I have no objection to him reading
16 that and asking questions.
17 BY MR. BAYMAN:
18 Q. "Question: Well, let's just talk a little bit,
19 and then we'll return to that because I know it's going to
20 be lunch hour pretty soon.
21 "Answer: Okay. So there's a sentence in the record
22 that says something like, quote, he doesn't have a
23 history of, I think it's, depression or suicidal
24 ideation, right?
25 "Question: I think it's words that affect.

1 "Answer: Yeah. So that would cover the present or
2 potentially the past. So clearly, Stewart didn't think
3 of himself as having had a serious depression, and I think
4 that's what consistent -- what Ms. Reed said. He typically
5 would go in and tell therapists, 'I'm very anxious.' So I
6 think that's a fine thing in the record. And I either think
7 he forgot the" -- there's an objection, overruled, and
8 then:
9 "Answer: So it says, no history of suicidal
10 thoughts. So, you know, he could have forgotten. We don't
11 know how she asked the question. We don't know how he
12 interpreted the question. It may be that -- and we talked a
13 little bit about this earlier that, you know, therapists and
14 doctors use 'suicidal thoughts' in a different kind of
15 way than the general public. And he may have said something
16 back in December 2007 like, quote, I'd like to fall
17 asleep and not wake up, unquote, and didn't even realize
18 that somebody would consider that suicidal. So I don't --
19 I don't have a problem with the fact that he said -- that her
20 note says no history of depression or suicidal thoughts
21 because the important thing is he wasn't suicidal on the 29th.
22 That's what we really need to know."
23 Now, do you --
24 THE COURT: Now the question.
25 BY MR. BAYMAN:

1 Q. Yes. Do you agree with Dr. Glenmullen based on what I
2 read that he may have -- Mr. Dolin may have forgotten his
3 suicidal thoughts or may not have realized he was expressing
4 suicidal thoughts on December 1, 2007?
5 A. No, I don't agree.
6 Q. In your experience interviewing people who've attempted
7 suicide, do they recall when they've had a prior -- prior
8 thoughts of suicide?
9 MR. RAPOPORT: I object, your Honor. He's not a
10 social worker or a psychologist, and it's not fair to compare
11 psychiatrists with other professionals if he's asking his own
12 experience, but how can he generalize that.
13 THE COURT: Read it back to me, please.
14 (Record read.)
15 MR. RAPOPORT: I also object because Mr. Dolin never
16 attempted to commit suicide. It's nonsense to suggest he did.
17 MR. BAYMAN: I'm not suggesting Mr. Dolin did. I'm
18 just suggesting he's interviewed people --
19 MR. RAPOPORT: It's not a fair analogy.
20 THE COURT: The objection is sustained. I think we're
21 off the track.
22 BY MR. BAYMAN:
23 Q. Well, in your interviews of patients who've told you that
24 they've had prior suicidal thoughts, is it your experience
25 that they recall when they've had those prior suicidal

1 thoughts?
2 MR. RAPOPORT: Objection. He can't get into other
3 people's minds.
4 THE COURT: Overruled.
5 BY THE WITNESS:
6 A. People don't forget when they have suicidal thoughts. It's
7 a scary thing and --
8 THE COURT: Keep your voice up.
9 THE WITNESS: It's a scary thing and people -- people
10 sometimes have trouble talking about it and relating the
11 information to other people. In the case of Mr. Dolin, he
12 didn't tell his wife back in 2007 that he had suicidal
13 thoughts. And I think he sometimes had trouble telling -- he
14 didn't tell Dr. Sachman he had suicidal thoughts. He had
15 trouble often telling people, but people do not forget.
16 That's ridiculous.
17 BY MR. BAYMAN:
18 Q. What did Dr. Salstrom include as Mr. -- as her diagnosis
19 for Mr. Dolin from that first visit?
20 A. She diagnosed him as suffering from generalized anxiety
21 disorder with especially -- I think she wrote something,
22 specially stressed at work or specially at work.
23 Q. Explain to the jury what generalized anxiety disorder is.
24 A. So that's a DSM-5, what we call DSM-5 -- I don't know how
25 to explain it quickly. It's the *Diagnostic and Statistical*

1 *Manual, Fifth Edition*. It has all the criteria for the
2 psychiatric diagnoses, and one of them is generalized anxiety
3 disorder.
4 The criteria are people who have feelings of anxiety
5 or nervousness plus additional symptoms: Insomnia, trouble
6 concentrating, sweating, fast heart rate, worries that
7 something terrible is going to happen. Those are sort of some
8 of the criteria for G -- what's called GAD, or generalized
9 anxiety disorder.
10 THE COURT: Okay. We'll recess now until tomorrow
11 morning at 9:30.
12 (Proceedings heard in open court. Jury out.)
13
14
15
16
17 (Proceedings adjourned from 4:24 p.m. to 9:30 a.m.)
18 * * * * * * *
19 C E R T I F I C A T E
20 We, Charles R. Zandi and Judith A. Walsh, do hereby
certify that the foregoing is a complete, true, and accurate
21 transcript of the proceedings had in the above-entitled case
before the Honorable WILLIAM T. HART, one of the judges of
22 said Court, at Chicago, Illinois, on April 11, 2017.
/s/ Charles R. Zandi, CSR, RPR, FCRR April 11, 2017
23 */s/ Judith A. Walsh, CSR, RDR, F/CRR* April 11, 2017
Official Court Reporters
24 United States District Court
Northern District of Illinois
25 Eastern Division