Transcript of

Peter Breggin, M.D.

Date: February 6, 2014
Volume: I

Case: Angel v. Segal, M.D.

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STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT - LAW DIVISION

LORRIE ANGEL, Plenary Guardian of MICHAEL ANGEL, a Disabled Person; and LORRIE ANGEL, Individually,	)	No. 09 L 003496
Plaintiff,	)	
vs.	)	
HOWARD MICHAEL SEGAL, M.D.,	)	
Defendant.	)	

EXCERPT REPORT OF PROCEEDINGS at the trial of the above-entitled cause before the Honorable ELIZABETH M. BUDZINSKI, Judge of said Court, on February 6, 2014 at the hour of 1:30 p.m.

Reported By: MARLO RODRIGUEZ, CSR, RPR
License No.: 084-004254

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APPEARANCES:
BURKE, MAHONEY & WISE & KAVENY, by
MR. FRANCIS P. MORRISSEY and
MR. BRIAN T. MONICO
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(312) 580-2040
Representing the Plaintiff;

PRETZEL & STOUFFER, by
MR. STEPHEN C. VELTMAN and
MR. SCOTT L. ANDERSON
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Representing the Defendant.

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(Whereupon, there were previous proceedings had that were not herein transcribed by the court reporter.)
(Whereupon, the following proceedings were held in open court.)
THE COURT: Call your next witness.
MR. MORRISSEY: Plaintiff calls Dr. Peter Breggin to the stand.
(Witness sworn.)
PETER BREGGIN, M.D.,
called as a witness herein, having been first duly sworn, was examined and testified as follows:
DIRECT EXAMINATION
BY MR. MORRISSEY:
Q. Good afternoon, sir.
A. Good afternoon.
Q. Could you introduce yourself to the jury by telling us your name, please?
A. My name is Peter Roger Breggin, MD.
Q. You are a physician?
A. I am, sir.

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Q. What kind of physician are you, Doctor?
A. I'm a psychiatrist.
MR. MORRISSEY: Your Honor, may I approach?
THE COURT: Yes, you may.
BY MR. MORRISSEY:
Q. Doctor, I will show you what's been marked Plaintiff's Exhibit 19 for identification.
Can you please take a look at that and tell me is that a fairly accurate and up-to-date copy of your curriculum vitae?
A. It is.
Q. Is that a document that accurately memorializes your achievements and publications in psychiatry?
A. It does, sir.
Q. Where did you go to medical school, Doctor?
A. Case Western Reserve in Cleveland.
Q. After medical school, did you do any further training?
A. Yes. I went to college at Harvard, and I spent a year back at Harvard Training Center and also at the State University of New York, Upstate Medical Center in Syracuse.

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Q. Did you do an internship following medical school?
A. Yes. That was in psychiatry and in medicine and that was my internship.
Q. At what institution, Doctor?
A. That was the State University of New York Upstate Medical Center.
Q. Following your internship, did you do a residency?
A. I did my first year at Harvard where I was also teaching fellows at Harvard Medical School and then I returned to the State University of New York Upstate Medical Center.
Q. Can you tell the ladies and gentlemen of the jury just in general terms what a residency is?
A. Well, in those days, when you finished medical school, you first did an internship usually in medicine. I was able to take half of mine in psychiatry. Then if you wanted to specialize in psychiatry, people generally took three more years of psychiatric training. I actually had three-and-a-half because I got a half of year in my residency.

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Q. After completion of the residency, did you begin the practice of psychiatry?
A. No. I went to the National Institute of Mental Health for two years.
Q. Tell the ladies and gentlemen of the jury about that experience.
A. Well, the National Institute of Mental Health is the federal government's agency for mental health and psychiatry. I was a lieutenant commander in the public health service. And I was considered a consultant in psychiatry at the National Institute of Mental Health.
Q. After your completion of that experience, what did you do next?
A. I went into a combination of private practice and teaching and research and writing.
Q. For how long have you been practicing psychiatry, Doctor?
A. Since my finishing at the National Institute of Mental Health. I actually started practice while I was there since 1968, a long time now.
Q. Doctor, have you held any academic appointments at universities across the country?

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A. I have.
Q. Can you tell the jury just a little bit about that experience?
A. Early on, I taught at the Washington School of Psychiatry. I taught in the counseling departments, not the medical school, but the counseling department at Johns Hopkins, at the University of Maryland. I also taught at George Mason University.
And for the last 10 years, I moved out of Washington DC to live in Upstate New York as I really like it there. And there I teach at a state university in Oswego in the counseling department.
Q. Is your current clinical practice your office practice in Ithaca, New York?
A. Yes, it is, sir.
Q. Can you tell the ladies and gentlemen of the jury what kind of practice it is?
A. Well, it's a combination. First, it's the general practice of psychiatry. I see children, but always with their parents because I think their parents are the most important factor in the lives of children.

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And I see adults. I do psychotherapy, family therapy, and consultations. And I have a subspecialty in clinical psychopharmacology; that is, the affects of medications on people.
So I do consultations with people from sometimes around the country both who have had adverse medication affects or adverse affects to shock treatment and even to lobotomy, which still occasionally goes on. So I have become a specialist in some of the harmful affects of the physical treatments in my profession.
Q. We will ask you a little bit more about that in a minute. Can you tell the jury what the International Center for Study of Psychiatry is?
A. In the 1972, I decided -- I sort of just got called into doing reform work. It began when I found out lobotomy was coming back. I conducted an international campaign to stop the return of surgical -- it's really mutilation of the frontal lobes of the brain. As a part of that, I formed the International Center for the Study of Psychiatry and Psychology to kind of give me support in the reform. This is unpaid voluntary reform work.

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My Board of Directors had a number of congressmen on it; Louis Stokes, Ron Dellums, a gentleman from Ohio, Steve Simms, because I was working with the Congress to stop these procedures. And we were very successful. That took several years of my life. That started the International Center for the Study of Psychiatry and Psychology.
Then when my wife, Ginger, joined me in about 1985, she really took over and made it into something more than just a support group with an occasional meeting, and we developed a journal published by a medical -- big medical publisher.
Q. What's the name of the journal?
A. When I started, we called it the Journal of Ethical Psychology and Psychiatry. And then the name was changed, and I am actually blanking on that right now.
Q. Is the Ethical Human Services --
A. It was Humans Services. We started with Human Services and then it became the Journal for Ethical Human Psychology and Psychiatry. I put together a board of contributors of 50 or 60 people from around the world.

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Q. What kind of issues are dealt with in the journal, Doctor?
A. Well, there are issues of ethics and of science and of the profession monitoring itself. It's one of the few journals specifically aimed at let's take an honest look at problems we may have in the profession, things we need to improve, what are the frontiers we need to be thinking about in delivering safe, effective and ethical care to children and adult patients. We also had annual meetings and newsletters and many other things.
Q. Now, you mentioned that you have a special interest in the pharmacology of medicines as it relates to children; is that right?
A. Yes, sir.
Q. Let's talk about that. First of all, how is it that you developed an interest in this area?
A. Well, I became very concerned in 1980's that my profession was more and more using psychiatric drugs. When I was in my training, you could go into a mental hospital for children, and most of them would not be on psychiatric

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drugs. Gradually over the years, it changed so much that you could go into a public school and half the kids might be on psychiatric drugs especially if they were problem kids in the schools.
MR. ANDERSON: Your Honor, may I be heard?
THE COURT: Side-bar?
MR. ANDERSON: Yes.
THE COURT: Yes.
(Whereupon, the following proceedings were held out of the hearing and presence of the jury.)
MR. ANDERSON: Now his work in 1980's against psychiatry is relevant? I have an objection to relevance about what he's doing against the profession and what other doctors might be doing related to overprescribing medication.
THE COURT: Move on. But I thought that's what you wanted to bring out in him.
MR. ANDERSON: But now he's opening the door to getting into what he --
THE COURT: Not the book. I told you you can get into all of the subjects but without referencing the book, everything that you spoke

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about earlier today.
MR. ANDERSON: I am objecting and ask that he move on because I think it's irrelevant.
MR. MORRISSEY: Okay. It's not irrelevant. I'm asking him his specific experience with pharmacology and children. This is the TD antipsychotics.
THE COURT: Right. Why don't you go right into that.
MR. ANDERSON: What other doctors are doing really is inflammatory.
THE COURT: I think you are going to bring that out on cross, aren't you?
MR. ANDERSON: No, I'm not.
THE COURT: He's on the outskirts.
MR. MORRISSEY: I will cut him off next time.
(Whereupon, the following proceedings were held in open court.)
THE COURT: You may proceed.
BY MR. MORRISSEY:
Q. Doctor, I think before we took that brief break, we were talking about your interest in pharmacology as it relates to children. I

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would like to just focus your attention on the issue of the use of antipsychotics in children and the possible side effects, okay? Have you studied that particular problem?
A. Yes. Starting in the 1970's, I began to notice that the antipsychotic drugs were causing tardive dyskinesia in children.
Q. Have you written any books on the subject?
A. Yes. In 1983, I wrote a book called Psychiatric Drugs, Hazards to the Brain. And that book contained the first lengthy discussion in a medical textbook of tardive dyskinesia in children and brought together many scientific articles that were already published and evaluated them.
And I drew attention to it as being a major issue and that the tardive dyskinesia was at least as frequent in children as adults. That was the beginning of my beginning to write about the subject.
Q. Over the years, have you continued to publish on the issue of antipsychotics for children causing tardive dyskinesia?

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A. Yes. A number of books -- just focusing on the medical books after the 1983 book, around 1997, from a medical publisher again, I published a book called Brain Disabling Treatments in Psychiatry which again had perhaps five chapters. All of the opening chapters are on antipsychotic drugs. And there's quite a bit of attention to tardive dyskinesia in several chapters and there's a discussion of the affects on children. That was then republished as a second edition in 2008.

And then in 2013, just last year, I wrote a book called psych -- again, a medical book. I have also written popular books, Psychiatric Drug Withdrawal it's called. It's a guide for prescribers, therapists, patients and their families. And it has a section on tardive dyskinesia as one of the reasons to withdraw children and adults from psychiatric drugs.

Q. You presented to either physicians, psychiatrists or lay people on the issue of tardive dyskinesia being caused by antipsychotics?

A. Yeah. I presented dozens and dozens of

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times to professional groups on the subject of tardive dyskinesia, especially a number of years ago when it was -- the need was there to get that information out before doctors became aware of it.

I gave a series of seminars at St. Elizabeth Hospital, for example, which is the big state mental hospital -- was big in Washington DC. I gave a series for doctors at Springfield Hospital.

In Maryland, I gave another single one at Manhattan State Hospital in New York City. But there were many, many of these and including some Canada -- to a hospital in Canada and also in Great Britain sometimes wholly about tardive dyskinesia and sometimes about a number of subjects including tardive dyskinesia.

Q. Has any government agency ever asked you to consult on the issue of antipsychotics and their side effects?

A. Well, the FFA asked me to consult on antidepressant drugs, not on tardive dyskinesia. But I have spoken at the National Institute of Mental Health and the National Institute of

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Mental Health talks -- that also had talks on tardive dyskinesia. Those are government agencies.

Q. Do you have any -- have you written in peer review journals, Doctor?

A. Yes. Probably more than 40 publications, scientific publications, in peer review journals.

Q. Would those publications have been related to the issue of tardive dyskinesia?

A. Well, three of them going back a number of years when people really needed the information, three of them deal in some depth with the antipsychotic drugs. They focus entirely on the antipsychotic drugs.

Q. What are the names of those journals?

A. Oh, gosh. One is Mind and Behavior. Y are giving me an old memory test here going back a long way. Oh, gosh. I have got them in my -- Brain and Behavior. One is Brain and Behavior. I forget the other two.

Q. But suffice it to say, tardive dyskinesia as a side effect to antipsychotics is very much a part of your current practice?

A. Oh, yes. In my current practice, I do

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consultations on the subject on a regular basis.

Q. In the Ithaca area or outside of Ithaca?

A. Well, most people -- people come to Ithaca if they want to have a consultation.

Q. Are these children who have tardive dyskinesia from elsewhere in the country?

A. Yes. Some of them are for medical-legal cases, and some are just consultations with parents wanting to know, you know, what's happening to my child. And even in the small community I come from, I see children occasionally with tardive dyskinesia and attempt to withdraw them from the drugs that are causing it.

Q. The jury has already heard a little bit about antipsychotics and what they are. And can you tell the jury just in general terms what an antipsychotic medication is?

A. Well, the antipsychotic medicines are not really specific necessarily for psychosis. Almost all of them have in common that they block the function of a major nerve trunk that starts deep in the brain in an area called the basal ganglia and spreads up into the frontal lobes of

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the brain. That's the newly evolved part of our brain that gives us a forehead unlike the animals.
Q. Doctor, would it be helpful if you would use the easel to explain to the jury about the function of dopamine in the brain?
A. Yes. And how the drugs affect it.
MR. MORRISSEY: Your Honor, may he step down?
THE COURT: Yes, he may. You may step down.
Mr. Morrissey, will you have Dr. Breggin face this way so the court reporter can hear?
THE WITNESS: I will have to move just once because I'm used to drawing from the other side.
THE COURT: Just so long as she can hear.
THE WITNESS: I am going to draw you the side of the brain, so it would be like you are looking at me. And I'm going to show you a cut across that brain. And I will do that in black. So here is a brain.
Now, this is up in here, the frontal lobes. So you can look at my head, my forehead. That's my forehead. The head is coming around like this, and you are looking at it sideways.

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BY MR. MORRISSEY:
Q. Now, let me ask you, you mentioned dopamine. Dopamine is a neurotransmitter did you say?
A. Yes.
Q. Is it a hormone?
A. No.
Q. Where is it produced in the brain?
A. Dopamine is produced deep in the brain in a place called the basal ganglia. It has several parts that I won't trouble you with.
So all that -- if you can remember back to biology, a nerve has a body, and it reaches to other nerves along a nerve fiber called an axilla. So the body is here, but it's reaching so that its electrical impulses going right along like that from the nerve body to where it's going, stimulate where it's going.
Q. Dopamine among other things helps control the movements?
A. Well, yes, because the basal ganglia are in center. So if you see people with Parkinson's disease, if they're having trouble moving, they have damage in the basal ganglia. If you see

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someone with Huntington's chorea and they're flailing around a bit, there's damage in the basal ganglia.
So the basal ganglia are central to movements that are supposed to be under our control. Damage releases the movements that are not under our control anymore. And I will show that to you.
Now, so let me draw how the nerves go. It goes up to the frontal lobes. So that should tell you also that this is not just a movement area, it's also got to do with your thinking processes indirectly because these projections are going all the way up into your highest thinking center.
Q. The antipsychotic medication we also were told is a dopamine blocker; is that right?
A. That's right.
Q. What does that mean?
A. Well, it means that the medications, pretty much all of them that are used are called antipsychotics. They all block the normal function of dopamine. And it's the normal function because it will block it in any human

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being even used in veterinary medicine.
So the affect of the drug is not dependent on who you are and whether you have a mental disorder or not. These are chemicals. They're blocking normal functions in the brain. And dopamine blocks -- I mean, the antipsychotic drugs, Risperdal is one in this case. Zyprexa is another in this case. They block this major pathway that's going to the brain, the front of the brain.
That immediate result is that people or animals become quieted down. They don't have their energy source. Think of them as diffused. This is like some of the input is gone.
MR. ANDERSON: Your Honor, I have an objection to the veterinary medicine component.
THE COURT: Yes. Just focus on human medicine.
THE WITNESS: Okay.
BY MR. MORRISSEY:
Q. That interruption, that interruption or blocking of the dopamine, does the brain react favorably to that, Doctor?
A. No. Well, the first thing that happens

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is the slowing down. Everything gets slowed down in the movements and everything gets slowed down. Also thinking gets slowed down.

There's a slowing down -- we speak of the person becoming indifferent, less energized, deactivated, maybe apathetic, slower. But the brain views this as a very severe disruption.

So what happens here in the basal ganglia is they start to get more excited. I'm just making little stars here. Obviously it's just a symbol. The nerves are saying we have to power up. We have to power up. We have to power up the big block. That power up you can actually measure on certain kinds of MRIs and other studies because things actually get more dense down here as it powers up.

Q. As a result of the hyperactivity and powering up as you say of the dopamine and the brain, what happens?

A. Well, two things happen; one is what you have been hearing about, tardive dyskinesia, tardive akathisia. These are all movements that are breaking out as this powers up because it's being blocked. It's powering up because it's

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being blocked.

So it just occurred to me it's like say your wheels aren't digging in. You start powering your engine up and start revving up. This thing starts revving up. That affects normal movements. It affects especially children. We see these abnormal behaviors. The system is just pushing so the child is emotionally out of control and physically out of control as a result of this revving up of tardive dyskinesia.

Q. Tardive dyskinesia, the jury has heard a lot about it already, but it is what in a nutshell?

A. Well, tardive dyskinesia is the abnormal movements sometimes with abnormal emotional states that are produced by dopamine blocking drugs. It's as simple as that.

Q. Tardive akathisia?

A. Tardive akathisia is one of the forms of tardive dyskinesia in which the body is driven to move, but it's driven by a mental component of anguish. The person who has tardive dyskinesia is experiencing very painful, indescribable

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feelings which are somehow relieved by moving.

And that combination of the inner emotional pain and suffering and the movements which are attempting to relief it, the person may not even know they're doing it, they just know they're moving. When they don't move, they feel that pain. That's tardive akathisia. It's a form of tardive dyskinesia that many patients describe as being like torture from the inside out. Even mild cases disrupt the ability to sit, disrupt the ability to go to work, disrupt the ability to sit down and relate to somebody.

Now, when you remove the blockage, you stop the drugs. And now we don't have the blockage anymore. I'm going to say we move the blockage. I'm going to leave some of it up. What happens? If caught early enough, this may simmer down. And you may have little or no obvious manifestations of tardive dyskinesia, but the longer and the higher the doses, but particularly the longer the exposure, we have many scientific studies on this, I mean, many, the longer the exposure, the more likely this will never simmer down.

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So your goal if you see anything like this developing is to stop the drug as quickly as possible. People can even be put in the hospital and stopped overnight. There's no problem stopping the drug, although it will produce a withdrawal reaction. You want to stop the drug and hope this simmers down. But when you have been on the drug for 2, 3, 4, 5 years, the odds become that it won't ever fully simmer down.

Q. Is one of the risk factors for developing tardive dyskinesia the length at which the blockade exists?

A. The length of time, the length of time. In fact, in the state mental hospitals when this was discovered where people are on these drugs for a long time, it was found that 50, 60, 80 and even 90 percent of patients had some signs of tardive dyskinesia because they have been on it for 10-15 years.

Q. Is another one of the risk factors for developing tardive dyskinesia, Doctor, the dosage at which the antipsychotic is prescribed?

A. Well, common sense would say the more of the offending agents you have and higher doses,

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and that is found, but not as consistently, it's definitely a factor, but the consistent factor is length of exposure. That's the one. And of course, it's the easiest one to study. If you try to study doses over 20 years in a patient, you can't even find the records. But you can find that they have been on it for 20 years. It's much easier to study length of exposure than doses of exposure. So length is really documented very heavily, dosage also.

Q. Thank you.

Doctor, just a couple more questions about TD. Did you say that the sooner you diagnose tardive dyskinesia, the better the chances of reversing the effects of it?

A. Yes, very definitely.

Q. Are there scales or tests that you as a psychiatrist can use in terms of evaluating a patient for tardive dyskinesia?

A. Yes.

Q. Are these tests, are they utilized by psychiatrists like yourself?

A. Yes. Since 1970's, there's been a scale called AMIS, the Abnormal Movement Inventory

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Scale. Its main purpose is for the doctor to have a place to write everything down and make sure he's looked at everything.

Q. Let me show Plaintiff's Exhibit 60 if I could.

Is this the AMIS scale that you were referring to, Doctor?

A. Yes.

Q. Can you just take us through how to use this AMIS scale in evaluating a patient for possible TD?

A. I don't think we can read that. There you go. Again, the purpose is to focus the doctor's attention so he/she are remembering to look at everything. Another purpose is for the doctor and anybody else who is involved in the case to be able to go back and say look at what the checklist was in July, now we are in September. We got more checks. So it's a recording system, but the doctor has to know what he or she is looking for.

So muscles of facial expression, it says movements of the forehead, eyebrows, periorbital, that's around the eye, cheeks including frowning

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and blinking, smiling and grimacing. Then you check it off whether it's none or minimal which is borderline, mild, moderate to severe.

Q. Then if you go to the right side of the chart or the test, it relates to extremities, trunk movements?

A. Yes.

Q. So you are not only looking at the face, are you?

A. No. If you go back, you will see the special focus on the mouth because some of the very earliest signs, not always, but some of the very earliest signs are abnormalities of the tongue so much so that the tongue gets its own section. You know, why is that? Well, that's because of a third to half of the cases are going to show up early on with tongue problems.

So you have to know about the tongue movements, tongue thrusting, tongue going in the cheek, tongue getting in the way of talking. Tongue is really critical. So the doctor has to actually have the patient open their mouth. This is not -- this is before you have ever seen any TD in the patient. This is to find the TD, not

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afterward.

To find the TD, the doctor has to open the patient -- ask the patient to open their mouth. And then you may need a flashlight or a good light, and you look in the mouth and look for tremors and squirming and the tongue will actually go back on the roof of the mouth. It's the most amazing thing to see in a person, this happening to them. And they may not know it other than maybe their speech is a little off or they are having trouble moving food around in their mouth. So you have to look because the patient may never realize what's going on.

And then you should look at them with the mouth open and then with the tongue protruding and you should also do what's called an activation movement, when people do something to distract themselves like a movement like one of them is where we tap the fingers like this, you do an activation movement, you will notice, look, he's starting to blink his eyes, he's not focused anymore, keeping his face under control. He is blinking his eyes or he is sticking his tongue out. While you are doing something like

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looking at the tongue, it's best to do an activation movement as well.
Q. You are looking at the face, the extremities, basically a head-to-toe examination?
A. Yes.
Q. Is that fair?
A. Yes. There's usually probably an instruction at the bottom to take off shoes. I don't know -- this particular one may not have that. I'm just not sure.
Q. How long would it take to perform this test?
A. You know, if you know what you are doing, it doesn't take more than 10 minutes. You know, it doesn't fit very well into a 15-minute med check, but 10 minutes maybe.
Q. This AMIS test is specifically designed to ferret out or to determine if a patient has TD, right, or abnormal movements?
A. To have abnormal movements and then to see it over time. So you do it each time. Many clinics require a doctor to fill it out every visit. You can actually go back and say, wait a minute, we are getting more and more of this

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stuff.
Q. Plaintiff's Exhibit 61, this is something called the Barnes Akathisia Rating Scale. You are familiar with this as well?
A. Sure.
Q. Is this like the AMIS scale that we just looked at, Doctor?
A. Yes. It serves the exact same purpose except it wants to focus on movements that are really driven and rapid movements, you know, slapping your hands on your body. Toe tapping is a really big one. People actually wear leather out of their shoes it gets so bad. Pacing, very, very, very common, pacing fast and hard, looking strange.
All of those things if you are on an antipsychotic drug, you have to right away, think, wait, wait, you know, this could be tardive dyskinesia or it's variant tardive akathisia.
Q. Doctor, you have reviewed Dr. Segal's office records in connection with your opinions?
A. Yes.
Q. And review of the case?

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Did you see anywhere in Dr. Segal's records either an AMIS scale or Barnes scale that had been completed on this patient, Michael Angel?
A. No, nor did I see notes that would indicate he had done an exam either.
Q. We will get to that in a little bit more detail in a minute. But in terms of this case, you understand you conducted what's called a medical-legal review?
A. Yes, sir.
Q. When did you start doing this kind of work medical-legal work, Doctor?
A. Oh, my gosh. I think I was a resident in psychiatry when I had to go to court and comment on one of my own patients. So this goes back to the late 60's, but I became most heavily involved in the early 1990's when the court appointed me to be the expert for over 150 lawsuits regarding the antidepressants, lawsuits against Eli Lilly for cases where allegedly Prozac had caused violent suicide, mayhem.
So when that happened, when I was asked to be the scientific expert for maybe 50

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different lawyers and couple hundred cases that I really began to do this work.
Q. You have acted as an expert in cases involving tardive dyskinesia?
A. Many. Yes, sir.
Q. Can you give a percentage breakdown for the jury in terms of how many of those cases were for the plaintiff versus defendant?
A. All of them are for the plaintiff because that's who asks me. I would love to do --
MR. ANDERSON: Objection, your Honor, foundation.
THE COURT: Overruled.
BY MR. MORRISSEY:
Q. Were you finished with your answer?
A. Yes. Just since it got interrupted, all of them as far as I can recall in this area are for the plaintiffs because my expertise is in the damage being done and in the standards of care.
Q. Do you charge for your time, Doctor?
A. Yes, I do.
Q. On an hourly basis?
A. Yes.

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Q. Can you tell the jury what those are?
A. It's $500 an hour.
Q. Now, did I supply you with Michael Angel's medical records from Dr. Segal?
A. Yes, you did.
Q. Then did I send you some more materials, Doctor?
A. Yes.
Q. Would that have included the deposition of Lorrie Angel?
A. Yes, sir.
Q. The deposition of Dr. Segal?
A. Yes.
Q. Deposition of Dr. Cabusao and Dr. Larsen?
A. Yes. Yes.
Q. And did you review those materials when they came to you?
A. Yes.
Q. Did you review medical records of Dr. Cabusao who is Michael's current treating psychiatrist?
A. I did, sir.
Q. Have you reviewed Dr. Larsen's records

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of the treating neurologist?
A. I did.
Q. If you offer opinions to this jury, Dr. Breggin, can I get your assurance that the opinions will be offered to a reasonable degree of psychiatric certainty based on your review, your education and your experience?
A. Yes. Psychiatric or medical certainty, yes.
Q. Have you formed opinions in this case to a reasonable degree of medical certainty regarding whether Dr. Segal complied with the standard of care?
A. I have, sir.
Q. Do you believe that he complied with the standard of care applicable to him?
A. No.
Q. Do you believe that Dr. Segal was professionally negligent during the near 3 years that he treated Michael Angel?
A. Yes, sir.
Q. Did the failure of Dr. Segal to comply with this applicable standard of care cause injury to Michael Angel?

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A. Yes, sir.
Q. Can you tell the jury what that injury is?
A. Well, it's life-long tardive dyskinesia and tardive akathisia which is being suppressed by large doses of antipsychotic drugs because if you keep raising the dose, you keep renewing that blockade that I described to you. So you increased the blockade again. Then it breaks through. You increase the blockade again. So he's in a cycle where he's going to need increasing doses to blockade. And this is only done in extreme circumstances where you need to suppress the tardive dyskinesia. And then it's going to be increasing problems from being on these antipsychotic drugs.
Q. We will get into this. Do you recall when the first time Michael and Dr. Segal met? Was that in February of 2005?
A. Yes, sir.
Q. Can we show the -- Doctor, is it your understanding based on your review of records that Michael was referred to Dr. Segal for medication management?

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A. Yes, sir.
Q. He first saw Michael on February 4th, 2005?
A. Yes, sir.
Q. At that time did he conduct an assessment of Mike?
A. Yes. Well, yes. He says he conducted an assessment.
Q. The assessment is in the records?
A. Yes, sir.
Q. Was Mike on any medication at the time?
A. Oh, yeah. He was on Risperdal and he was on Paxil.
Q. Now, did Dr. Segal put him on the Risperdal or the Paxil?
A. No. The patient came to -- Michael came to him on both of those drugs.
Q. When a patient comes on medication to a new psychiatrist, is that psychiatrist to be compliant with the standard of care? Is that psychiatrist obliged to reinform or inform the mom in this case because she's acting for her child about the risk and benefits of an antipsychotic medication like Risperdal?

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A. Yes, he is.
Q. To comply with the standard of care, what did Dr. Segal need to say?
A. Well, when we go to a doctor, you know, as a reasonable person, we have the right to know the information that we are going to think is important to the safety and effectiveness of the drug.
So a person needs to have the information that a reasonable human being would want to know about the risks and the dangers, the effectiveness, the alternative treatments, and with a lot of emphasis when you are using such a powerful drug on the risks. We all would want to know the risks. That's the standard what a reasonable person would be and would want to know.
Q. You reviewed Dr. Segal's records. Did he chart anywhere that he had a discussion with Mrs. Angel about the risk and benefits and the potential side effects of Risperdal?
A. No.
Q. To comply with the standard of care, did Dr. Segal have to tell Mrs. Angel that the use of

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Risperdal was an off-label use of the drug?
A. Yes, sir.
Q. Why is that?
A. Well, the FDA sets up standards. And under the law, those standards are for the safe and effective use of the drug. So they approve a drug. It means that in the judgment of the FDA working with the drug company, the drug is safe and effective to use.
If the drug is used off label, it hasn't gone through the process of being studied for safety and effectiveness. Now, many doctors make judgements that a drug may be useful to their patients off label. For example, an antibiotic might be approved for one kind of pneumonia and the docs find out, it's useful for other pneumonias. There's nothing wrong in itself to use a drug off label. But when you are using a very powerful drug off label in a child not approved for children at that time, the parent, a reasonable parent, would want to know that. You are using a drug that was developed for schizophrenic adults and indeed they are tested on people who have schizophrenia for years and

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years. A parent would want to know that.
Q. Did the standard of care require Dr. Segal to inform Mrs. Angel that one of the potential side effects of the drug was tardive dyskinesia?
A. Yes.
Q. Did it oblige Dr. Segal to actually use the words tardive dyskinesia?
A. Yes.
Q. Why?
A. Well, if you just say as he did -- says he said at his depo, that he mentioned movement disorder I think is what his words were or something close to that, that could mean many different things. It could mean the stereotypies of autism. It could mean anything that would be in the imagination or not in the imagination.
But if the doctor says tardive dyskinesia, then the reasonable person can actually Google it, which people do all the time now, and look it up and discover what it is and understand it. And secondly, it needs to make clear that this is a very specific threat of this drug called tardive dyskinesia and then to

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describe it.
Q. Did the standard of care require Dr. Segal to actually describe what those abnormal movements associated with tardive dyskinesia actually looked like?
A. Yes. There's two reasons why the parent needs to know what the movements look like; one, in order to decide whether she wants to subject her son, Michael, to the risk. But there's another reason, if she goes along with the drug, approves the drug being given, you want her, who is going to be with the boy every day, to know what the symptoms look like in order to immediately recognize them and call the doctor because as I mentioned earlier, the sooner you recognize the symptoms and stop the drug, the more likely that they may just go away entirely. It's not uncommon in children for them literally to disappear never to be seen again.
So since the parent is the one who is going to be seeing the child, in this case, every day compared to the doctor who may see the child once a year as he did or once every six months as he did, the parents got to know what to look for.

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So those are two reasons; one, so the parent could decide is this the drug I want my child to have or do I not want to risk tardive dyskinesia. And having agreed to the drug, the parent needs to be able to identify what this is the moment it happens.

Q. Based on your review of Dr. Segal's deposition and his records, you are aware that Dr. Segal mentioned the possibility of abnormal movements, to be on the lookout for them associated with Risperdal?

A. Yes. That's what he says he did.

Q. Was that a deviation from the standard of care in simply saying abnormal movements?

A. Yes. It was for the reasons I said.

Q. Was it also incumbent or obligation of Dr. Segal to tell mom that tardive dyskinesia can become a permanent condition?

A. Yes. Absolutely. I mean, that's the real risk here is that you end up having this for the rest of your life.

Q. Why is that? Why did she have to say -- why did Dr. Segal have to use those words, tardive dyskinesia can be a permanent condition?

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A. Because it's incredibly important information for the parent to have or the young adult to have in order to make a judgment of the risk of taking the drug.

Q. Based on your review of Dr. Segal's deposition and all of his office records, did you see any mention of Dr. Segal ever telling Mrs. Angel, A, that this antipsychotic was being prescribed off label?

A. No.

Q. That this antipsychotic could cause a permanent movement disorder called tardive dyskinesia?

A. No.

Q. And to be on the lookout, mom, for abnormal movements of the face and of the arms and extremities?

A. No.

Q. Was that a deviation from the standard of care?

A. Yes.

Q. Do you also have an opinion, Doctor, to a reasonable degree of psychiatric and medical certainty whether or not Dr. Segal deviated from

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the standard of care in his failure to monitor Michael Angel while he was on antipsychotic medications?

A. Yes.

Q. And tell the jury what your opinion is in that regard.

A. Well, in his own signed standard for how his practice operates, he says, you know, I have to be able to see you every three months, leave some room for an exception, but every three months you need to come in and be seen if you are going to be on medication.

Well, in general you need to come in and be seen every three months. If you are getting an antipsychotic drug, the most dangerous drug, class of drugs, then you surely have to come in every three months or shorter. So he deviated from his own set standard by going at 1.6 months and another point a year.

Q. What did the standard of care require of him? How frequent was he required under the standard to have frequent visits to monitor Michael Angel for adverse drug effects of the antipsychotic?

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A. Well, I think his own signed standard was adequate. I would want it more often, but every three months unless you got some real reason to suspect it's happening.

Q. Can we look at that office policy? Is this what you are referring to, Doctor? It's Plaintiff's 2.3?

A. Yes.

Q. I believe it's Paragraph No. 5. It says, quote, the minimum frequency of visits for routine medication management is every three months unless we have made other arrangements. Did I read that correctly, Doctor?

A. Yes, sir.

Q. Based on your review of the deposition, did you review Mrs. Angel's deposition?

A. Yes.

Q. You reviewed Dr. Segal's deposition. Any talk of an arrangement different from this one?

A. No. There was no discussion of an arrangement, but honestly, counsel, if there had been an arrangement, it would have been wrong because that's the minimum. And on an

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antipsychotic drug in a child who has been on it for years, you don't want the minimum. You want the most stringent. So there could have been no arrangement that would have been ethical or proper.

Q. Then the office policy goes on, if it has been more than six months since our last visit, your case will automatically be closed. Did I read that correctly?

A. Yes, sir.

Q. Based on your review of the depositions and the office records of Dr. Segal, did this patient go more than six months without being seen in the office?

A. Yes. The patient went a whole year.

Q. Pardon?

A. A whole year, sir.

Q. Was that a deviation from the standard of care to let a patient, a child who is on antipsychotics, go a full year without being seen in the office?

A. Yes, sir, it was a deviation.

Q. What harm would that cause?

A. Well, the whole issue is to be able to

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catch tardive dyskinesia early on to stop the drug the sooner, the better. And indeed when the person has been on this many years, to be seeing the patient with the goal of removing them from the drug because the risk of tardive dyskinesia is escalating each year in adults. The rates of tardive dyskinesia are 5 to 8 percent a year. We are talking about huge rates.

So at 3 years, you have a 15 percent risk in adults or more, 20 percent risk in adults. There are multiple scientific studies on this, multiple, multiple authoritative resources saying high, high rates. And they accumulate. So your risk goes up and up with each other year. So you get a youngster like this who has been on for several years, you have to be monitoring and attempting to remove from the drug unless you have some really overriding reason not to, not to remove them. You still have to monitor.

Q. Hypothetically, if a psychiatrist decided to rely on mom to report any changes instead of getting the patient back in every three months, hypothetically, would that be compliant with the standard of care?

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A. No. For several reasons; first, mom can't do the AMIS scale routine. I mean, she doesn't know about looking at the walking and making a quick move and the other things we know, standing, sticking your arms out and arms up and down and opening your mouth and do some activation movements with your tongue out. She's not going to be able to do all of that. That's a very critical reason why.

And secondly, I mean, the physician is the one who knows what this stuff looks like or should know what this stuff looks like. It's very easy for the family to think it's just nerves or nervousness. Case after case I have seen, not necessarily just legal cases, just case after case, the person starts to get some strange movement and the family thinks it's crazy.

I remember a boy sitting my office, his arms going up. And the mom is saying put your arms down. I said, mom, he doesn't even know he's raising his arm. He is talking to us and his arm is going up. So the family thinks usually that it's just weird. And it's extremely important for the doctor to be looking at the

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patient.

Q. Let's go to that first visit with Dr. Segal on February 2005. Do you recall whether or not he had gotten a report about Mike's behavior at school?

A. Yes, he had.

Q. Take a look at that. This is Plaintiff's 2.4. You have seen this before, Doctor, right?

A. Yes, I have.

Q. Is this a document that was contained in Dr. Segal's file?

A. Yes. You can see it's dated a couple days before.

Q. February 2nd, right?

A. Yes.

Q. Anything on this report that would be indicative of either tardive dyskinesia or tardive akathisia?

A. Well, there's a discussion of his jumping around and his moving I think is in here somewhere.

Q. How about the first paragraph --

A. Let me catch up with you here.

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Q. How about the first paragraph, the second sentence begins other times, are you with me, Doctor?
A. Yes.
Q. It says other times his behavior seems to be out of his control. He appears unhappy and anxious? Do you see that?
A. Yes. Jumping around is from somewhere else. The out-of-control behavior, that could be behavior, but that could be the boy can't stop himself from moving.
Q. What is that, Doctor, when you can't stop yourself from moving?
A. If he couldn't stop himself, it would be tardive dyskinesia. It doesn't tell you it's tardive dyskinesia, but it should get you thinking.
Q. I think later on it talks about --
A. Slapping his hands on his legs.
Q. What is that indicative of, the slapping of the legs? Tell the ladies and gentlemen of the jury what that is.
A. Well, again, it's indicative of tardive dyskinesia. It doesn't by itself tell you

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because some of the most common things people do is they're moving while they're sitting still to try to relief it, and that could involve slapping or as I mentioned earlier tapping feet. So it's another signal, potential signal.
Q. You reviewed the entirety of Dr. Segal's records from this visit?
A. Yes, sir.
Q. Did he conduct an AMIS or Barnes test?
A. No.
Q. Did he write anything in his chart about potential tardive dyskinesia or tardive akathisia?
A. No.
Q. By the way, you reviewed his deposition, did you not?
A. Yes.
Q. Based on your review of the deposition, did you have an understanding of whether Dr. Segal knew what tardive akathisia was?
A. No. It was very surprising. When asked, he said he was not familiar with the term, not familiar was his word with the diagnosis.
Q. Likewise was Dr. Segal familiar with

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tardive akathisia being caused by antipsychotics?
A. He was not.
Q. I would like to go to June 2006, where there's a report of seizure-like activity. Do you remember that, Doctor?
A. Yes.
Q. This is Plaintiff's 2.6. This is from June 15th, 2006. Am I right, Doctor?
A. Yes, sir.
Q. Let me ask you, the visit before this, this is about a year ago?
A. Yes, sir.
Q. Is this the extent of the note, this one page?
A. Yes.
Q. Do you see up at the top, it says had, question mark, seizure-like episode?
A. Yes.
Q. Am I reading that correctly?
All right. What is the significance of that report?
A. It has two significances which should have led to a lengthy description and analysis. One is sometimes it's been reported that autistic

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children have seizures. So you want to know if that's a possibility and evaluate it.
But more commonly, a person -- a family member seeing initial tardive dyskinesia will think it's a seizure-like episode.
Let's suppose that a child has an aspect of TD. In this case, eyes are rolling back in the head, kid is getting stiff, arching his back, looks like a seizure. Let's suppose the arms are moving out of control, looks like a seizure.
It is one of the most common things that you see in a medical record a parent saying or a husband or a wife saying that is the first sign of the onset of tardive dyskinesia. But however you look at it, you can't have in the record six little abbreviated words about a seizure. I mean, you have to get serious about it.
Q. Any evidence from the chart that Dr. Segal further investigated this report of seizure-like activity or episode?
A. No.
Q. You read his deposition. Did he say that he followed up on that?
A. No.

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Q. He's on Zyprexa as you can see at the top. He came to this office visit already on Zyprexa, didn't he?
A. Right.
Q. Do we know when the first time Dr. Segal switched Mike from Risperdal to Zyprexa?
A. Well, we can figure it out from the pharmacy records. The doctor didn't know, but the pharmacy records say April was the beginning of the Zyprexa.
Q. So about two months before this office visit, Dr. Segal switches Mike from Risperdal to Zyprexa, right?
A. Yes.
Q. Zyprexa is another antipsychotic?
A. Yes.
Do you mind if I check that date because it's so important and I just want to make sure I'm not making an error there? It's April 18th, '05. That's what I thought, but the pharmacy record says unless I'm in error which is possible, but it's April '05.
Q. Then he sees Mike in June of '05 as well, right?

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A. Yes.
Q. So on this visit then is the next visit which is about a year later?
A. Yes.
Q. He's still on the Zyprexa?
A. Yes.
Q. And the dose, 30 milligrams, is that a high dose?
A. The 30 milligrams is a -- yes. It's above the recommended dose for adults who are schizophrenic. 20 milligrams is the recommended upper dose for adults.
Q. Based on your review of the pharmacy records from Walgreen's, you did look at those?
A. Yes, sir.
Q. Had Dr. Segal given six-month refills?
A. Yes.
Q. Was that a deviation from the standard of care to have given six-month refills?
A. Yes.
Q. Why is that?
A. Well, it enables the patient not to come every three months. And it gives the patient the mistaken view that, hey, you know, you can go six

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months. I have given you six months of refills for the drug without seeing me and it makes it possible.
Q. How did that deviation cause any harm to Mike Angel?
A. Well, again, it kept him from being monitored and evaluated by the doctor and lulled the mom into thinking this was not a serious issue, that she really needed to get her son in.
MR. ANDERSON: Objection. Speculation and foundation.
THE COURT: Can you read back the end of that answer, please.
(Whereupon, the record was read.)
THE COURT: I will strike the last part. You can disregard that.
BY MR. MORRISSEY:
Q. Now, let's go to July of 2007. There's not going to be a record in his chart about this. But are you aware that Lorrie Angel called Dr. Segal's office to complain of Michael having tongue thrusting?
A. Yes, sir.
Q. Tongue thrusting, what is the

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significance of it?
A. It's as clear of statement that the person is developing tardive dyskinesia as you can possibly get. Tongue thrusting is one of the real characteristics of the early development of tardive dyskinesia. It could be a thrusting out of the mouth.
As I mentioned earlier, it could interfere with swallowing, the speech. You can bite your tongue. You go to the doctor. The doctor could look in and actually see bite marks on the tongue because the tongue is just moving out of control. You can see little ulcers from previous biting of the tongue. You can see sometimes the lip has been chewed.
So we are talking about something that is a key sign of tardive dyskinesia. It is in my experience and in the scientific literature, it is never just an acute phenomena. It's not just hey, look, the drug did this one day out of the blue. It's always associated with tardive dyskinesia.
Q. In your understanding, this phone call was made to Dr. Segal's office about mid July?

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A. Yes, sir.
Q. When did Dr. Segal have Mike back into the office after --
A. It was months.
Q. August 22nd?
A. It was just one month? I thought it was even longer. Okay.
Q. August 22nd?
A. Yes. I have it. I better use my notes on numbers. It was August 22nd, '07, eight weeks later, two months.
Q. Even then based on your review of Dr. Segal's testimony and his review of the records, he did not diagnose Michael Angel with TD on August 22nd, 2007, did he?
A. No.
Q. Was it a deviation of the standard of care, Doctor, when Dr. Segal received a report of tongue thrusting in mid July not to have Michael Angel into his office sooner?
A. Oh, yes. I mean, he should have had him in as quick as he could get him there.
Q. When he did have him in on the 22nd, you see there he notes tongue thrusting?

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A. Yes.
Q. Anywhere in the record or the chart is there a reference to TD?
A. No.
Q. Or TA?
A. No.
Q. You read his deposition. Did he say that based on his examination of Mike Angel on August 22nd, 2007, that it was his opinion that Mike had TD?
A. No.
Q. Did he ever tell Mrs. Angel during this office visit that her son had TD?
A. No. He wouldn't necessarily write down that he had TD. He would have to write down probable TD and started a complete evaluation is what he would have to do, not TD, but probable TD and a real evaluation or referral to a neurologist.
Q. He didn't do either one of those?
A. Right. That could involve blood tests. It could involve all kinds of different things.
Q. He wasn't even thinking about TD, was he?

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A. No. He said in his depo he didn't know that tongue thrusting was an early sign of TD at that time, but he had learned since.
Q. Dr. Segal thought it was the dystonic movement causing this, didn't he?
A. I think -- yes. And I think -- yes. He seemed to think it was an acute phenomena.
Q. Are dystonic movements different from TD movements?
A. I have to -- it's a little complicated. Initially all of the things you see in TD except tongue thrusting, incidentally, almost all of the things you see later in TD can happen acutely. Then you have to get worried, is it going to get permanent, is it going to be TD.
Let's say you get akathisia, a person is jumping all around. Your first thought is, oh, it's akathisia. Is it going to be an acute one or is it going to be a persistent one, be TD. You don't get acute. You got a dystonia that was acute. Dystonia is a muscle spasm and the neck is out of shape literally for the rest of your life. It could be out of shape. That could be acute, but then it becomes persistent. It's

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tardive dystonia, a long-term thing.
The issue here is you don't get an acute dystonia years into treatment and more than a year into treatment with this drug. When it starts showing up, then it's actually TD breaking through the masking. It's the TD breaking through.
Q. What harm did Dr. Segal's failure to diagnose TD on August 22nd, 2007 cause to Michael Angel?
A. It caused him continuing exposure into October to these drugs which was a continuing process of firming up the persistence and severity of the disorder.
Q. August 22nd, 2007, was that the last visit with Dr. Segal?
A. Yes, sir.
Q. Did you understand from your review of the depositions that mom and Dr. Segal had a discussion about getting a second opinion about what was happening with Mike?
A. Yes.
Q. Mike went to another psychiatrist by the name of DiMatteo, Thomas DiMatteo?

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A. That's right.
Q. Dr. DiMatteo, what's your understanding of for how long he treated Mike?
A. You know, I'm not absolutely certain. He treated him through October.
Q. So a couple of months?
A. Yes. Not very long.
Q. Do you recall that Dr. DiMatteo tried a trial of Seroquel?
A. Yes, sir.
Q. And did --
A. I do.
Q. Did that work?
A. Well, no. No, because Seroquel is not as strong of dopamine blocker, so it's not going to block as much. So you are going to get the TD showing up more.
Q. Also Mike was seen by a neurologist, a Dr. Larsen?
A. Larsen, yes.
Q. Did you review his records?
A. Yes.
Q. Did he come to any conclusions or diagnoses about Mike and what was causing these

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problems?
A. Yes. He concluded it was TD, and he also described classic TD, not just the tardive akathisia where you are jumping around, but lots of other symptoms, eye blinking, and I think facial grimaces. There was a whole bunch of things that pretty much tell you this is TD. Nothing else quite looks like it.
And then when you have after years of exposure to the neuroleptic, it's -- every time I have seen, it's turned out to be TD and not some other neurological disorder.
Q. When Dr. Larsen saw Mike in his office in Naperville, was Mike on any neuroleptics or antipsychotics then?
A. Yes, he was.
MR. ANDERSON: Objection to form.
THE COURT: Can you narrow it down?
BY MR. MORRISSEY:
Q. Your recollection is that Michael saw Dr. Larsen in approximately October 30th, 2007, Doctor?
A. Yes. Let me review a little bit just about that. Let me get my memory back on that.

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Yes. He saw him in October and December. Yeah.
Q. Then look up at the screen here, Doctor. This is an excerpt from his first -- this is Dr. Larsen's letter to Dr. Carducci. He says he's been off since October 25th for about six days now?
A. I'm sorry about that error.
Q. That's all right. Does that refresh your memory then?
A. Yes.
Q. Was Mike on any antipsychotics when Dr. Larsen saw him?
A. No. That would be why he saw all of the symptoms. They were not being masked.
Q. The symptoms of TD?
A. Yes.
Q. Did Dr. Larsen also see symptoms of tardive akathisia?
A. Yes.
Q. Do you recall did Dr. Larsen recommend that the family go to a Dr. Emma Cabusao?
A. Yes.
Q. For management of the medication?
A. Yes.

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Q. You reviewed Dr. Cabusao's medical records, did you not?
A. Yes, I did.
Q. Was it your understanding when Mike went to Dr. Cabusao that Dr. Cabusao was trying to treat his movement disorder, TD?
A. Yes.
Q. Will you tell the ladies and gentlemen of the jury what kind of medications or alternative treatments she was trying to help his TD?
A. I think she started him on Seroquel, didn't she? Or am I getting a little lost here?
Q. No. I think it was clonidine.
A. On clonidine.
Q. On clonidine first.
And can you tell the ladies and gentlemen of the jury how clonidine -- what that does in terms of the treatment of TD?
A. Well, clonidine is not a treatment for TD, but it is used sometimes to try to control movement disorders. And it's not going to do much to a significant TD. It's not going to touch it much.

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Q. Let me ask you this, once TD becomes permanent, or it becomes, you know, permanent, is it reversible?
A. First, long-term studies, most cases don't get better. When they have gone on for months, hardly any get better. You will see some improvement in about a third, a third staying about the same, and a third getting worse. But once you have been there for years, you don't see these resolving and just disappearing.
Q. In this case, did Dr. Cabusao try alternative treatments and with no success?
A. With no success, yes.
Q. That resulted in Dr. Cabusao putting Mike back on the offending medication which was the Zyprexa; is that right?
A. Yes, sir.
Q. Does the Zyprexa control the TD?
A. It suppresses the expression of the TD.
Q. Is that called masking?
A. Yes.
Q. Please explain to the jury what masking is.
A. Well, remember when I drew the lines

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through and said that the Zyprexa blocks the dopamine activity, so if you give the offending agent, you will block some extent of manifestation of the symptoms. But the symptoms are still cooking underneath. The basal ganglia damage is getting worse most likely because of the continued exposure.
So all you are doing is putting a cover on the lid. It's like putting a top on a pressure cooker. And maybe it will hold and maybe it won't. Maybe it will blow off and you will end up with a much worse than ever TD. Maybe you will be fortunate, and it will hold the lid down.
But meanwhile, you are going to have the damaging affects of the continued exposure of this drug, which is not only damaging the basal ganglia, but it's damaging nerve cells in general, exposing the patient to a worsening of all of the heart risks and aging risks, diabetes, and elevated cholesterol and shortened life span.
We have more and more evidence now. There is a whole book written about it. It deals with the shortening of life span from continued

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exposure of many years to these drugs.
Q. Is Michael Angel destined for a life on these antipsychotics, Doctor?
A. Yes. I have not seen anybody who has reached this condition come off of them simply because it would unmask something even worse than we had before.
Q. We know that Mike had autism; is that right?
A. Yes. That seems to have been fairly clearly established and described.
Q. Would Mike's underlying autism have destined him for a life on these drugs?
A. Absolutely not. Autism is primarily a disorder of social relationship. You can think in terms of Dustin Hoffman playing the Rainman. Or there's a woman you may be familiar with who is a very famous autistic woman who has written about taking care of cows and animals. I'm skipping on her name right now. You have probably read books by her. Temple Grandin, Temple Grandin. She's an autistic woman. She's a much older person now. I have seen her. She gives speeches and goes around talking about

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helping animals and being humane to animals.
So the social deficit, which begins pretty early in life to be called autism, you will have to some degree, probably most of your life, but it doesn't carry with it a physical underlying disease and deterioration. Now, sometimes autistic kids also have some epilepsy, but that's not part of autism.
Autism is very specifically defined as the early onset of difficulty relating to human beings as human beings, just don't have that empathic connection. A typical thing a mother will say is he treats me like a table or chair. He will push past me like he's not hurting me. It's a lack of connectivity. It is not diagnosable as a physical disease. People with autism can live full lives, and they can grow old.
If they don't get treatments, that is going to be very injurious to them. And the treatments they need are not the drugs. I mean, the general agreement is the treatment they need is wraparound care. He was getting that at his school, wraparound care, concern. The parent

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needs to be encouraged to relate more. It's all about drawing the child socially into a relationship with you.
MR. MORRISSEY: Your Honor, may I have a moment?
THE COURT: Yes, you may.
MR. MORRISSEY: Doctor, just a couple more questions.
BY MR. MORRISSEY:
Q. You mentioned in addition to being destined for a life on these antipsychotics, Mike also had an increased risk for developing some of the other side effects for being on these drugs, which would include you mentioned metabolic syndrome. Can you tell the ladies and gentlemen of the jury what that is?
A. The newer antipsychotic drugs have now been studied very carefully, and they commonly cause aspects of what's called the metabolic syndrome. It involves elevated cholesterol, which is a heart risk. It involves elevated blood sugar and then diabetes which is a heart risk as well as a risk for many other things. And it involves obesity, which is a risk for

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hypertension and also for heart problems.
And these drugs can also disrupt cardiac rhythm, so that's a added-on risk. That's one of the reasons why these drugs are shortening life span. There are studies out that show that a third of children on these drugs will develop something like a metabolic syndrome, so it's common. It's a serious risk.
And he began to show signs of both elevated sugar and elevated lipids during Dr. Segal's treatment because he did correctly send him for lab studies and he did have elevated lipids already and he had elevated sugar.
MR. MORRISSEY: Thank you, Doctor. Those are all of the questions I have.
THE COURT: Thank you, Mr. Morrissey.
Let's take our afternoon break for about 10 minutes. We have a snack here. And we will come back of after that.
Remember, do not discuss the case, do not do any internet research, Facebook, Twitter, blogging, all of that jazz regarding your jury service, the parties, the lawyers, the witnesses, the medical issues, the drugs, et cetera. We

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will see you in about 10-15 minutes.
(Recess taken.)
THE COURT: Mr. Anderson?
CROSS-EXAMINATION
BY MR. ANDERSON:
Q. Good afternoon, Dr. Breggin.
A. Good afternoon, sir.
Q. If my voice drops out, will you please say something. I have been told sometimes I drop off, so I will try not to.
A. Me too.
Q. Let's work together.
A. It will be quite a combination.
Q. We will keep our voices up. I placed over almost behind our court reporter's head the deposition of Lorrie Angel. Could you turn, please, to Page 131?
A. Okay.
Q. Earlier when you were testifying, you had indicated that there might have been as much as an six-to-eight-week gap between the time these symptoms were reported -- strike that.
You actually said there was a six-to-eight-week gap between the time these

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symptoms of tongue thrusting were observed and the time she got into Dr. Segal.
Mrs. Angel's deposition testimony reflects that as soon as she perceived her son was having these symptoms, she called Dr. Segal that day or within a couple of days, right?
A. Well, I have to read this. Do you want me to read this?
Q. Yes. Read to yourself Lines 6 through 10, 6 through 10 on Page 131.
A. Okay.
Q. Thanks.
Doctor, would you agree with me that TD is a rare condition?
A. Oh, my Lord, no. No.
Q. No?
A. No. The rates in adults are 5 to 8 percent a year cumulative so that according --
Q. My question was just --
MR. MORRISSEY: Your Honor, may the witness be permitted to answer?
THE COURT: It's his examination. You can redirect him. Did you want to -- you can finish.

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BY MR. ANDERSON:
Q. In terms of the studies that you cited, many of the studies deal with state hospital settings when people were on the older generation antipsychotics, right, the early studies?
A. Well, those were the early studies, yes. There are many new ones.
Q. These drugs, these atypical antipsychotics started coming out in the 90's?
A. Yes.
Q. First one was what?
A. Risperdal. Well, Clozaril, but Clozaril is actually a very old drug that got revived.
Q. Then Risperdal?
A. And Zyprexa.
Q. Then Zyprexa sometime thereafter. So these starting coming out in the early 90's?
A. I think it was '94 for Risperdal and '96 for Zyprexa, something close to that.
Q. You were talking about this AMIS scale that's performed. That does require the cooperation of the patient, right?
A. Parts of it, but not all of it. Most of it is observations.

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Q. The part where you are asking the patient to open the patient's mouth, that requires cooperation?
A. Yes.
Q. You say when you perform this test, you remove some outer articles of clothing to try to get a better look at the patient?
A. We don't want the patient draped. The only thing I ask people to take off is their shoes and socks so I can see their toes.
Q. That requires also the cooperation of the patient, right?
A. Oh, yeah. The mother, mother could take off his shoes and socks I'm sure.
Q. Still requires the cooperation of the patient, that's all I'm asking?
A. To some extent.
Q. Do you do an AMIS test or AMIS scale on every patient at every visit?
MR. MORRISSEY: Objection, your Honor. Motion in limine. Personal practice.
THE COURT: Sustained.
MR. ANDERSON: This is on cross-examination, your Honor.

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THE COURT: Sustained.
BY MR. ANDERSON:
Q. Did you see an AMIS scale on Dr. Larsen -- strike that.
Did you see Dr. Larsen performing an AMIS scale?
A. No.
Q. Did you see Dr. Cabusao perform an AMIS scale?
A. No.
Q. Did you see Dr. DiMatteo perform an AMIS scale?
A. No.
Q. Did you see Dr. Klapman perform an AMIS scale?
A. No.
Q. Doctor, you are not board certified, are you?
A. No. I never took the boards.
Q. You are not board certified in either psychiatry, child psychiatry or this clinical pharmacology area that you have an interest in, right?
A. There is no board for clinical

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psychopharmacology.
Q. But you are not a child or child --
A. No. I never took the board years ago.
Q. You never examined Michael Angel?
A. No.
Q. You agreed that he had autism when Dr. Segal was treating him?
A. Yes, sir.
Q. He started as having mild to moderate autism with Dr. Klapman and then it became more severe around the time that Dr. Segal started seeing him; is that right?
A. No.
Q. That's not right?
A. Not in my opinion, no.
Q. Doctor, referring you to Page 40 of your deposition. Do you have your deposition?
A. No. But go ahead. I mean, I know what I think. I'm sure I said the same thing then as I will now.
Q. I'm not so sure, so let me show it to you.
I'm going to talk to you about Page 40, Doctor.

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A. Okay.
Q. Dr. Klapman described -- I'm looking at Line 9. Dr. Klapman described Michael Angel as having a more mild form of autism; is that right?
A. Well, I think in the record, he might have said mild to moderate. Then I think he might have said mild in his depo. But these are such -- mild to moderate, you know, they're so subjective. It's not like we have a number scale.
Q. I'm just trying to ask my questions. So the question I'm asking you, Doctor, now is about Dr. Segal, the bottom of Page 40?
A. Okay.
Q. Do you have an opinion as to whether he looked more severe at the time he saw Dr. Segal?
A. Yes.
Q. He was moderate to severe, correct?
A. Yes. But sir, you didn't actually --
Q. I didn't ask you anything else.
A. Well, I mean, you can read the next part of my depo where I explain it.
THE COURT: Doctor, Mr. Morrissey are --
MR. ANDERSON: I would like to go home

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tonight.
BY MR. ANDERSON:
Q. Your experience with autism, Doctor, you have treated about ten patients over the last ten years?
A. Yes.
Q. You have never had an occasion to treat a young patient with autism who was on neuroleptics, right?
A. No. I don't think I have.
Q. You don't think there's any successful treatment for moderately to severe -- for a moderately to severely autistic child. Did I ask that badly? Should I try that again?
A. It's up to you, sir.
Q. Did you understand?
A. Well, I think so. But there are very good treatments for autistic children, not drugs.
Q. Never drugs?
A. But not drugs. Generally not, no.
Q. Now, you actually never had an occasion -- strike that.
You prefer not to use drugs in your treatment of patients?

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A. Yes. I try to help people psychologically, work with their families, work with the children, bring in the grandparents. I think families are the most healing thing that we have for distressed people. But other doctors use drugs as a first line.
Q. You have no experience starting a patient on Risperdal, do you?
A. No. Probably not. I have lots of experience --
Q. Doctor, I only asked about Risperdal. Was that a yes or no to my question?
A. Only with people already on Risperdal, lots of experience.
Q. I'm talking about starting. You never started a patient on Zyprexa either, have you?
A. No.
Q. You have never started a patient on Paxil, have you?
A. No.
Q. You never started a patient on Celexa, have you?
A. No.
Q. You agree with me that that practice of

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not having that kind of experience puts you outside the main stream of most psychiatrists, right?
A. I think you asked a compound question. Certainly most psychiatrists start patients on drugs all the time. I do not.
Q. That puts you outside the main stream of psychiatry, correct?
A. Yes. Common practice in psychiatry is to start drugs the minute you walk in the office.
Q. Just because a patient develops TD while taking a neuroleptic, it doesn't necessarily mean that the prescribing doctor violated the standard of care, does it?
A. No. Not at all.
Q. In terms of risk factors for TD, how long the patient is on the neuroleptic is more important than the dose?
A. Yes. As far as we could tell.
Q. At one point in time it was thought that TD was more common in women. I know that's not the view now, but at one point in time, is that true?
A. Yes. That's right.

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Q. At some point in time it was thought the risks of TD were less with atypical, say the second generation neuroleptics, as opposed to the first generation?
A. Well, depends on who you are asking.
Q. I know you didn't have that view. But in the main stream psychiatry and psychological community, didn't they?
A. Yes. I think they believe the drug companies initially.
Q. That's where I was going to go next. That's how the drug companies market these drugs, right?
A. That's right.
Q. We talked before about the test. There is no test for TD. You refer to the AMIS scale and the Barnes scale, right?
A. That's correct. There's no physical test.
Q. TD commonly starts in the face and the tongue, true?
A. Yes. Commonly, not all the time.
Q. You and I talked -- strike that.
You and Mr. Morrissey talked about this

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February 2nd, 2005, remember that?
A. Yes, sir.
Q. Can you see that okay?
A. Yes. Pretty well. Pretty well.
Q. If you need me to zoom in on something, we will try my skills for zooming in.
You believe that some of these behaviors are early signs of TD, right?
A. Potentially.
Q. And I want to ask you about TD because you at times have used TD, tardive dyskinesia, and tardive akathisia interchangeably?
A. Yes. Sometimes.
Q. And for purposes of this case, are you using them interchangeably?
A. You just have to ask me at any given moment. I could explain if you wish.
Q. Well, do you believe that these signs that we are -- these behaviors here, do you believe those are signs of TD or signs of TA?
A. I believe they're signs of the variant of tardive dyskinesia that we call tardive akathisia.
Q. So that's the TA I asked you about?

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A. Yes. So you could always say they're signs of tardive dyskinesia, but it's the variant of tardive akathisia?
Q. So when Michael Angel came into Dr. Segal's office, he had some of those variant signs?
A. Yes.
Q. In particular, you believe the slapping of the hands on the legs and the emotional lability while laughing are signs of TD?
A. More the slapping of the hands on his legs and his lap the doctor describes, but the emotional lability -- the slapping of his hands on his legs, the doctor also says he saw him slapping his chair and slapping his lap, and that that had been going on for awhile.
But he reports in his depo he actually saw this himself, and those would be signs of TD and it's possible that the out-of-control behavior also related to the TD, but that's harder to determine.
Q. But you still -- you thought it was possible?
A. Possible, yes.

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Q. That's the emotional lability, right?
A. Yes. Important to evaluate.
Q. But behaviors that are within Michael Angel's control are not TD or TA, correct?
A. Oh, actually, with effort, people can control to some degree the tardive phenomena. It's exhausting unlike the stereotypies you have heard about. So someone who is raising their arm, you can say I want you to hold your arm down. You will see him start to sweat, so they have partial control sometimes for a limited amount of time.
Q. So you do not agree that the TD is the part where it's outside the control of the patient?
A. In general, but they can sometimes partially control it.
Q. Looking back, you actually believe banging of objects, screaming, laying on the floor, occasionally kicking people and objects, tapping of objects, really the whole works here is TD, right?
A. No.
Q. No?

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A. No.
Q. You don't think the whole works is TD?
MR. MORRISSEY: Objection as to the form, Judge.
THE WITNESS: No.
THE COURT: Overruled.
BY MR. ANDERSON:
Q. Doctor, you did give a deposition in this case?
MR. MORRISSEY: Page and line, counsel?
MR. ANDERSON: Can I get there?
BY MR. ANDERSON:
Q. You did give a deposition in this case?
A. Of course.
Q. I traveled out to Ithaca in the dead of winter to take your deposition, right?
A. I don't even remember the season.
Q. Well, you now repaid the favor because you came to Chicago in the dead of winter.
At Page 66, Lines 8 through 23, the banging of objects, the screaming, the laying on the floor, the crying, the occasional kicking of people and objects and the tapping of objects could be related to autism and not TD?

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Answer, I would say no. I think eventually what we are going to find as we see the TD evolve is that this is TD, the whole works, and can't separate it though from the drive -- the drivenness that is coming from the Paxil which is a very stimulating drug that makes children frequently out of control. It's very hard because we don't have the records to decipher all of this, but as we get into the TD later on, a lot of this is the extreme he didn't have when he first presented to Klapman.
Were you asked that question and did you give that answer?
A. Yes. It's very different than what you asked me.
Q. I'm sorry, I didn't hear you. Yes, you gave that answer?
A. That's very different from what you asked me.
MR. MORRISSEY: Objection, your Honor, not impeaching.
THE COURT: Sustained.
BY MR. ANDERSON:
Q. I went through the whole list and I will

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do it again.
Do you believe banging of objects, screaming, laying on the floor, the crying, the occasional kicking of people and objects and the tapping of objects is TD?
A. I think that we have both as I said in there, the antidepressants, the TD and possibly even autism is contributing to all of this. What I said was that all of this should alert you to TD and that looking back, I thought it was TD. I didn't say that doctor looking at this whole ball of wax would say TD. I never said that.
Q. If I implied that, I apologize because I was going to get to that question, which is you are not saying that the minute Michael Angel walked into the door and Dr. Segal got this list, he should have said that's TD? You are saying retrospectively, these behaviors could be signs of TD?
A. Yeah. I made that clear on my direct.
Q. That's what I'm -- that's what I'm asking you about.
A. Sure.
Q. You think that this is in part due to

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the drivenness that's caused by Paxil, right?
A. I said could be.
Q. You said Paxil could make children be out of control?
A. Oh, we have so many studies on that. It's really sad, yes.
Q. You think it might have been reasonable to look at this list though and believe that these were behaviors related to autism also?
MR. MORRISSEY: Objection, form, relevance.
THE WITNESS: No.
THE COURT: Overruled.
THE WITNESS: I'm sorry.
BY MR. ANDERSON:
Q. Would it have been unreasonable to look at this list and say that this could be related to the fact that the child is autistic?
A. Sure. You could raise the question of that. But you know, go ahead.
Q. Go ahead.
A. No. I'm going to stop. You have told me not to speak too much, so I'm going to try not to. As hard as it may be, I'm going to try not to.

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Q. We will go with that.
If he was like this before he was started on Paxil, would that make it more likely that these behaviors were not caused by Paxil?
A. Yes.
Q. That's sort of logical, right?
A. Well, before he was started on antidepressants.
Q. Right.
A. Not just Paxil because he was on Zoloft before this --
Q. SSRIs and all of that?
A. Into a past we don't even have records of.
Q. You read -- I'm about to get into that. You read Dr. Klapman's deposition?
A. Yes.
Q. Now, Michael presented to Dr. Klapman for the first time on January 17th of 2000. Will you take my word for that?
A. Oh, I know. He had just turned 8.
Q. As of the time he presented to --
A. No. He hadn't quite yet turned 8. Go ahead.

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Q. As of the time he presented to Dr. Klapman, he was already on Zoloft as you just said?
A. Yes, sir.
Q. Dr. Klapman's initial impression was OCD or obsessive compulsive behavior?
A. Yes, sir.
Q. There's also a concern about anxiety?
A. That's right. And autism.
Q. And autism.
And in May of 2000, he discusses emotional lability?
A. Yes.
Q. We talked about what that is before, right?
A. I don't think you asked me what that is.
Q. I think we did, but I will ask you. Tell us what emotional lability is.
A. It usually means rapidly and seriously fluctuating emotions, fluctuating emotions in a way that's not normal.
Q. So that's reported in May of 2000, correct?
A. Yes, sir.

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Q. Then in June of 2001, there's a discussion about anxiety and behavioral problems, true?
A. That's right.
Q. Then on April 30, 2002, do you recall that Dr. Klapman wrote a letter to a judge?
A. Yes, sir.
Q. Do you have that in front of you?
A. I do in here somewhere, but I think I can work without it.
Q. If I put it up here, will that help?
A. Sure. Whatever you want.
Q. Can you see that?
A. Yes.
Q. First paragraph is Michael had been diagnosed with profound autism, severe apraxia. Can you help me with that one? I'm not sure we have that defined yet. Do you want to help me with that one?
A. Apraxia is difficulty carrying out a purposeful movement on instruction. One of the little tests we use is we put a piece of paper in front of somebody and we say please fold the paper left to right and put it in your lap or

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something like that. And some people have trouble doing that, but it can be limited to one area of activity. It can be more global. There's never been any evidence he had apraxia though.
Q. Dr. Klapman is providing evidence there's apraxia and he's telling the judge this in April of 2000 --
A. No, he's not. He says he's been diagnosed with severe apraxia. He himself never saw any evidence for it.
Q. Then there's sensory integrative disfunction and obsessive compulsive disorder?
A. Yes, sir.
Q. The next sentence says seizure disorder could not be ruled out due to the fact that the child could not tolerate a diagnostic 24-hour EEG. That's a test to determine whether someone has seizure activity?
A. Yes. But you would start with just a simple EEG, which doesn't take much time at all. And I don't know that was ever done. I don't know why he's talking about a 24-hour. You don't go to that right away.

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Q. He talks about the very hard work that Mrs. Angel has done to get her son into the right school program. Then he says he brought -- Michael's mother brought him in to see me due to increased obsessive compulsive behaviors and issues associated with the sparse and infrequent and random --
A. Yes, sir.
Q. Michael has become extremely agitated, moody, and his obsessive compulsive behaviors would elevate?
A. Yes.
Q. Did I read that correctly?
A. Yes.
Q. Being that he could not verbally express himself, his anxiety would manifest itself into ritualistic behaviors that he could not control or self-regulate. I read that correctly?
A. Yes, sir.
Q. Very briefly, Doctor, could you describe ritualistic behaviors. What are those?
A. Well, we all do them. We all have ways of controlling our anxiety. Some people count to themselves. Some people do real rituals like

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pray. I pray when I get anxious.
Here it refers to something that, you know, we consider abnormal. Maybe the child won't step on cracks in the sidewalk hoping that that will relieve his anxiety. So there are little things people do. It may range from very normal to real impairing. There are little things people do on a routine basis to try to calm themselves, soothe themselves.
Q. After the last visit with the father on September 7, 2007, Michael's anxiety increased to a point of self-injurious behaviors of which consisted of head banging. Did I read that right?
A. Yes.
Q. Undoubtedly these behaviors hurt the child emotionally and carried through all environments including interference with ability to learn and function at school. The elevated state of anxiety has been known to last for six to eight weeks. Did I read that correctly?
A. Yes, sir.
Q. One of the main deficits and concerns of autism is the child's inability to tolerate

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change. Routine and predictability are essential to an autistic child's emotional well-being. Do you agree with that last sentence?
A. Oh, yeah.
Q. Doctor, this was as I said written on April 30, 2002. That's before Michael Angel was put on any neuroleptics, right?
A. That's right. He's on antidepressants, which are more likely to cause that behavior.
Q. He was on Paxil, right?
A. Yes.
Q. You have a concern about Michael Angel being on Paxil, don't you?
A. Oh, yes.
Q. You don't think it's a good idea to give Paxil to an autistic child, do you?
A. No, I don't think it's a good idea. I don't say it's negligent necessarily, but I don't think it's a good idea.
Q. Understood.
You believe Paxil can cause akathisia?
A. It's not my belief, sir. It's a scientific fact that it causes akathisia. You can look it up in the diagnostic and statistical

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manual --
Q. I'm not fighting with you, and I'm not trying to say this is your belief. I guess I'm trying to say you agree Paxil can cause akathisia?
A. Yes. Not tardive akathisia.
Q. But it can cause akathisia?
A. Yes.
Q. It's not below the standard of care to prescribe Risperdal or Zyprexa?
A. I'm sorry, I couldn't hear.
Q. That's okay.
It's not below the standard of care to prescribe Risperdal or Zyprexa to a child with autism?
A. Well, now Risperdal is approved for giving it to children with irritability who have autism. So no, it's not below the standard of care. Now, it's not.
Q. Dr. Segal saw this patient on February 4th, 2005. We talked about that. That was the first visit?
A. Yes, sir.
Q. At that time he took a history?

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A. Yes, sir.
Q. His notes reflect he was aware of Paxil?
A. I'm sorry?
Q. His note reflects that he was aware that Michael was on Paxil, right?
A. He was on Zoloft.
Q. I'm sorry, he was on Zoloft -- no. He wasn't. He was on Paxil?
A. I think he changed him from Zoloft to Paxil, sir.
Q. Right. As of that first visit, just focusing on that February 4th, 2005?
A. He's on Zoloft, sir, the first time he sees Klapman.
Q. I'm talking about Dr. Segal.
A. Oh, we are up to Dr. Segal. Yes, of course he was aware he was on Paxil.
Q. He was actually concerned that the Paxil might be causing behavior described as mania, true?
A. That's right.
Q. His plan at that time, February 4th, 2005, was to begin to taper down Paxil?
A. That was a good thing.

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Q. Thanks for getting to my next question. So that was reasonable to do?
A. Not so fast, but it was reasonable. But not fast like he did.
Q. Well, you can't just take someone off an antidepressant, right?
A. No. You have to go slowly after all of those years.
Q. You agree with that too, that's a good idea to taper it slowly?
A. Very slowly.
Q. It's also reasonable to taper it and monitor the behavior that happens in follow-up with the patient?
A. That's right.
Q. You have said Paxil -- strike that.
Coming off of Paxil can be a horror show of anxiety, upset, and aggressiveness and instability, true?
A. Yes.
Q. It can make the autism worse?
A. Oh, yeah.
Q. It's also impossible to say how long that process takes, that withdrawal of Paxil,

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true?
A. That's right. It could grow fairly rapidly or it could be very slow. Some adults can't even get off Paxil.
Q. It's variable? It's variable?
A. That's right.
Q. Now, in terms of separating TD and TA -- strike that.
You would agree with me that TD, the signs of TD, were apparent toward the end of Michael's treatment with Dr. Segal when there was a report of tongue thrusting? You told us about that earlier, right?
A. I don't think that's when it started.
Q. The medical documentation of this was first reported with tongue thrusting in August of 2007?
A. That was -- that was when you got a symptom that was so -- could only be explained by TD just about, but there were earlier signs.
Q. That's what I was going to get to.
Your belief was that it might have been there for a few months before?
A. Yes. But I mean, there were earlier

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signs other than tongue thrusting.
Q. When Lorrie Angel -- strike that.
In the face of signs of TD, you would agree that stopping the offending drug or what you think might be the offending drug may not necessarily be reasonable?
A. Well, sometimes it's impossible, but it is the first step you are supposed to take.
Q. Well, or tapering the drug?
A. Oh, yeah. Yes. Stopping or tapering.
Q. So continuing the drug, but at a reduced dose would be a reasonable thing to do, wouldn't it?
A. Yes. With the goal of getting more.
Q. Pardon me?
A. Yes. With the goal of stopping the drug.
Q. In fact, that's what Dr. Segal did on August 22nd, 2007 when he cut the dose of Zyprexa in half in response to a complaint of tongue thrusting, right?
A. Yes.
Q. Now, Dr. Segal testified in his deposition that he performed an examination and

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he, himself, did not see any tongue thrusting, correct?
A. He said he didn't see any tongue thrusting, yes.
Q. Now, let me back up one second. You were talking earlier about earlier signs of TD. What do you mean by that in this history?
A. Well, in his depo, Dr. Segal says that this slapping that he was talking about that -- that had been going on for a long time and he saw it in the office, he doesn't write it down, but he said he saw the slapping movements in the office.
That should alert you to the tardive akathisia which is a form of tardive dyskinesia. That should make you think, my gosh, I mean, toe tapping, that's like slapping, these movements, I ought to be really thinking about this.
Q. Anything else?
A. That was the main thing. And you know, just some of the activity in the write up that he got at the same time.
Q. That list that we gave --
A. Yeah. We talked about that.

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Q. Again, those were as of February 5th or -- strike that.
Those were as of February 2nd, 2005, before he even got to see Dr. Segal?
A. Yes. Two days.
Q. We have sort of danced around this issue of the PDR. I want to talk to you directly about the PDR. PDR is generated by drug companies?
A. Yes, sir.
Q. In consultations with the FDA?
A. No, sir.
Q. How is the PDR generated?
A. PDR is just a book in which manufacturers can pay to put their labels. The PDR is not what you are talking about. What you are trying to talk about is -- I don't mean to be condescending. These are complex issues. What you are trying to talk about is the label for the drug --
Q. You are right.
A. -- which goes into the PDR sometimes, but not always.
Q. The label that goes into the PDR, which is really what I was aiming at.

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A. It doesn't always go in, but yes.
Q. But it's the result of a negotiation process between the drug company and --
A. The label is as a result of the negotiation. The label is what you heard of as the package insert. It is the basic information that the FDA -- it's the FDA that really controls it. The FDA puts together on the basis of working it out with the drug companies, what kind of safety information, what kind of effectiveness information would go in. You see it in the ads of the back of your magazine. You would be looking through a men's or women's magazine advertising a drug. You see a page that's a summary of the -- just a summary.
Q. You don't think it's a good idea for the doctor to rely on just what the pharmaceutical company says about the drug?
A. No.
Q. You would equate that to relying on a car salesman?
A. Yes, sir.
Q. A used car salesman?
A. Yes, especially the salesperson who are

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coming to the office talking -- I think I made that reference in comparison not to the PDR, but to the salesperson who comes to you selling the drugs to ask them about an adverse effect would be like --
Q. You just said car sales?
A. Get the car facts, you know.
Q. In and of itself the off-label use of drugs though as you have said repeatedly is not a violation of the standard of care?
A. No, it is not, sir.
Q. Changing of drugs from one to another doesn't automatically violate the standard of care either, does it?
A. No, of course not.
Q. Sometimes that's done to achieve a better condition for the patient?
A. Sure.
Q. In terms of vulnerability for developing TD, I think you said, but I want to make sure I heard this, there's no difference in the vulnerability between children and adults which is to say they have the same vulnerability as an adult?

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A. They seem to have the same general vulnerability. I don't know if we have enough studies to really hammer that out. But the children are very vulnerable to TD.
Q. They're no different than adults?
A. You know, I don't think we know for sure some of that stuff. I mean, there are studies showing that if you look at a group of children and say an institution for autistic and retarded kids, a third of them are going to have some signs of TD if they have all been on these drugs at one point in time, which happens in institutions. And we learning not to do that anymore.
Q. Let me follow-up with you on this from Dr. Larsen, February 12th, 2008. Do you see that?
A. That's a little hard.
Q. I'm sorry, I want you to see it. Can you see it better now, Doctor?
A. I'm sure the jury could see it better now too.
Q. You have read this. This is part of your review?

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A. Yeah. We went over this earlier, I think.
Q. As of February 12, 2008, Michael Angel is not on any neuroleptics, right?
A. Right.
Q. I want to ask you about a behavior that's depicted in the second paragraph. You want to read that? I will read it. In general, he's been doing much better in terms of his tics, vocalizations, banging, anger, and akathisias. Unfortunately, he's been to the timeout room several times in school and first took off all of his clothes and urinating and then urinated and defecated and smeared it on the walls. This caused him to be taken out of school. Is that behavior TD?
A. It's drug withdrawal. It's withdrawal from the neuroleptic drug. The drug remember has been suppressing, suppressing, suppressing and now the poor child is bizarrely out of control worse than he's ever been. We have multiple studies on this. And I have seen it in my own practice last year. That's exactly this. I had to hospitalize a child because his behavior got

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so bad. Fortunately the hospital worked with me in getting him off --
Q. So it's just a response to withdrawal?
A. This is kind of a worsening behavior. It's well known, well documented. Waldtiere has written studies on it. Other people have written studies on it. I see it in my own practice. It's well known. It even has names, tardive dysphoria, tardive psychosis. Literally people end up psychotic who were never psychotic before when they come off these drugs.
Q. So it has nothing at all to do with the drug itself? It's the withdrawal from it, that's your position?
A. It is the damage done by the drug and now you are in withdrawal from the drug. And it may not just be withdrawal. It may be that the person stays like that.
Q. Let me follow-up with a few questions. You were asked early on about your qualifications and then I'm going to be done. Okay?
You left Harvard after your first year, so you didn't complete your residency at Harvard, true?

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A. That's right. I preferred it in Upstate New York.
Q. This work for the National Institute of Mental Health. That was not a clinical practice, was it?
A. No.
Q. It was building clinics and providing children educational services?
A. There's two separate things. For the first year, I traveled around the southeastern part of the country teaching communities how to set up mental health centers. So that requires a lot of clinical knowledge, not treating people, so I did a lot of, you know --
Q. In terms of faculty work you have done, that's never been teaching MDs? It's been counseling programs, right?
A. The university appointments have mostly been counseling programs. But of course, I give conferences where MDs get credits for coming. I have written articles where they get credits for reading.
Q. I know. I'm just trying to talk about your faculty appointments.

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A. No. The faculty appointments have almost entirely been in counseling departments where I find a really comfortable home because the counselors have a more understanding of empathy, caring, relating to people.
Q. The ISCPP, the International --
A. The ISCPP. Of course, I have not -- I moved on. I have set up a whole new organization.
Q. I know that, but that's the International --
A. International Center for the Study of Psychology and Psychiatry that I formed in 1972 as part of the anti-lobotomy campaign.
Q. You were the director up to 2002?
A. Roughly.
Q. You then became emeritus director from 2002 to 2010 and then you disassociated with that organization?
A. Yes, sir.
Q. Your wife had helped you with that organization?
A. Oh, she helps me with everything except my clinical practice.

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Q. As I told you the last time I saw you, no disrespect to your wife, but she doesn't have medical training, right?
A. No disrespect, sir. No. She's just the most brilliant person I know.
Q. Thankfully you were consistent. That's what you said at your deposition too.
Doctor, in terms of presentations, you are a life member of the American Psychiatric Association?
A. Yes, sir. That means I grew old in the association.
Q. You have actually -- the last time you presented though in the association was 30 plus years ago?
A. Many, many years ago, yeah. Actually it was during the anti-lobotomy campaign.
Q. That goes back to the 70's?
A. 70's.
Q. In terms of your medical-legal review, you have reviewed hundreds of cases, true?
A. Yes, sir.
Q. You have testified at trial 80 times or more?

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A. Well, since 1987. That list of '87 is not all trials. But since 1987, I have probably been in about 75 trials. So that's a lot of years. Probably 3 a year I think is an average.
Q. This is not your first visit to the witness chair in the Daley Center, is it?
A. No.
Q. Is this the third or fourth trip?
A. Well, I was here twice as far as I know. You want to talk about the cases?
Q. No. We have enough to talk about without that.
A. Or the outcomes?
Q. You last testified for a defendant in a medical malpractice case in the 1980's?
A. That's correct.
MR. ANDERSON: Your Honor, may I cover one issue with you outside the presence of the jury?
THE COURT: Yes.
(Whereupon, the following proceedings were held out of the hearing and presence of the jury.)
MR. ANDERSON: Two things, two things, your Honor, under the authority of Walski versus

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Tsagna, 72 Ill. 2nd 249 -- wrong case. Strike that.
I'm asking for permission to question this doctor regarding his personal practice to impeach him. I believe that's permissible.
THE COURT: It is, but what do you want to do --
MR. ANDERSON: My question about the AMIS test was to impeach him. I don't think he performs an AMIS test for every visit.
THE COURT: Oh, I understand. His testimony was that you should do that on --
MR. ANDERSON: I don't know what his testimony is. His testimony is it has to be done regularly. And my question is does he -- you know, he's making it sound like it's a nothing test.
THE COURT: I thought his testimony was wouldn't you have signs -- there's some signs.
MR. ANDERSON: You have to look for it is what he's saying. He did say you have to look for it at every visit. And you have this test up here acting like you are going to Jiffy Lube. I just want to say, look, you don't do it at every

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visit.
MR. MONICO: He did not say you do it at every visit. He said it's something you do over a period of time with seeing a patient. He didn't say you do it every visit. If you are a physician that sees your patient on a regular basis, you probably don't have to do it. If you are doing it once a year, maybe you should be doing it.
MR. ANDERSON: I made my request. All I'm trying to do is ask his personal practice. He does not perform these.
THE COURT: Has he ever performed them?
MR. ANDERSON: I don't know.
THE COURT: I don't know his testimony.
MR. ANDERSON: I'm flying blind. I don't know.
MR. MORRISSEY: He didn't ask these questions in the dep. So I mean, that's the problem we are having. I don't think you get to introduce personal practices unless they --
THE COURT: Unless they vary from what he said the standard of care was, but he did not say the standard of care was performing these tests.

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MR. ANDERSON: Okay. That's fine.
Second issue, different issue, I would like to renew my request to bring in the subject of the bowel movements with Dr. Klapman to the extent he has claimed that all of these prior behaviors were TD or TA caused by other drugs and Dr. Klapman and did not have this young man on any of those -- I'm sorry, did not have him on any antipsychotics at the time that he was playing with his bowel movements.
MR. VELTMAN: If I could just add to that, what has changed on the scope of things is that he has now taken a look at the 2008 activities that were in the February 12th letter at school and said that also is related to the drug withdrawal.
I think we should have at least an opportunity now through our expert, if not on cross-examination of Dr. Breggin, to point out that this behavior now existed prior to the neuroleptics and after the neuroleptics because he's blaming it on the drugs.
MR. MORRISSEY: Your Honor, I think your ruling before was pretty clear that we would stay

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away from the prior episode and we would focus on that. I didn't ask any questions about this. It was brought up on cross. He walked into it, and he asked are these behaviors consistent with just his underlying behaviors? Are they coming out now. He didn't get the right answer he wanted. That's not my fault.
MR. ANDERSON: I got exactly what I wanted.
MR. MORRISSEY: That's not my fault.
THE COURT: Wait. Wait.
MR. MORRISSEY: You don't get to --
THE COURT: I think they're completely different behaviors. I mean, he is having an anxiety attack, whatever he is doing in the room, and the problem I have with that incident is that Klapman didn't do anything in response to it. And he didn't even ask about it at the next visit.
MR. ANDERSON: He wasn't on any drugs that supposedly caused it. The neuroleptics supposedly caused the behavior because what he's saying over there -- this is why I asked him that because I wanted to hear it. He's saying that the behavior in 2008 was withdrawal from

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neuroleptics. He wasn't on any neuroleptics.
MR. MONICO: You are taking a leap and saying that because someone does two things, therefore, the exact same reason, there's no tie up there. Someone can do two -- do the same thing for several different reasons, whether it's mania, whether it's psychosis, whether it's whatever. It doesn't matter.
So I don't see how you get to now bootstrap in what you wanted to ask him simply by asking him this question. We all knew what the answer is going to be now what that condition was. You don't get to bootstrap now all of a sudden and go around the ruling by saying he's now created an issue. You have opened the door. That doesn't mean that we have opened the door or the things change -- if the door isn't open, then there's no reason to be addressing it.
MR. MORRISSEY: I didn't even address it with him on the direct.
THE COURT: I was going to say they are trying to say that he wasn't on drugs and what does that behavior -- what does that behavior mean?

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MR. ANDERSON: I understand what you are saying which is you are not convinced there's enough probably a description of this to --
THE COURT: If this behavior is associated with autism or associated with this, we are going to follow this behavior because it's serious behavior, then I get it. I don't know if it's just a three-year old acting like a three-year old. That's my concern about it. I mean, I wish we could have, you know --
MR. VELTMAN: Just two points briefly, Klapman did testify that he thought it was a significant event that made him consider Risperdal. He did not view it as a three-year old playing as a three-year old. It was a significant event in the autism that he testified raised it to a more severe autism.
And what I think since our expert is entitled to criticize and respond to are the opinions given in court of Dr. Breggin that I would expect what our expert would do then is to say I disagree with Dr. Breggin's --
THE COURT: What did your expert say about that incident? Did your expert address that

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incident?
MR. VELTMAN: The February of '08 incident?
THE COURT: No. The first fecal incident when the child was young and he --
MR. VELTMAN: No. I don't think so.
MR. MORRISSEY: And he doesn't get to address it now. What's said in open court, he can't comment on. That's improper.
THE COURT: Well, you can do it hypothetically, I think.
MR. MONICO: It needs to be disclosed.
THE COURT: That's my concern. None of this has been disclosed or brought out by these experts. None of them has been relied on it and says that this shows his behavior was X, Y, and Z. I don't have anything to tie it together. So I'm going to let it out. I am going to stand on my ruling.
MR. ANDERSON: In this case, I'm done.
MR. MORRISSEY: I have five questions.
(Whereupon, the following proceedings were held in open court.)
MR. ANDERSON: Your Honor, thank you.

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Dr. Breggin, thank you. I have no further questions.
THE COURT: Mr. Morrissey, redirect?
MR. MORRISSEY: Yes, Judge, very briefly.
REDIRECT EXAMINATION
BY MR. MORRISSEY:
Q. Hello again, Doctor. I promise to be quick.
Remember you were talking with counsel about early signs of TD and you went over the stuff from February 2nd. Do you remember that?
A. Yes, sir.
Q. You also talked about the tongue thrusting on August 22nd, 2007. Do you remember that?
A. Yes.
Q. Then there was that visit in between, wasn't there, June 15th, and there was the seizure-like activity?
A. Yes.
Q. Could that be a sign of TD?
A. Yes.
MR. ANDERSON: Objection. Beyond the scope. I never raised that issue.

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THE COURT: Overruled. Overruled.
BY MR. MORRISSEY:
Q. Doctor, seizure-like episode, can that be early evidence of TD?
A. It's really common for parents to describe that or spouses to describe that because of the unusual movements. And they're out of the person's control, so maybe that's a seizure, understandable mistake.
Q. So it appears like the patient is having a seizure when in fact it's just abnormal movements?
A. Yeah. It appears to the layperson understandably, probably not to a trained physician, but even there you can get confused.
Q. I believe also on that record, it said something like Mike Angel had lots of jumping around. Do you remember that?
A. Yes.
Q. What's the significance of that?
A. Well, as soon as you see that with someone on antipsychotic drugs, you have to worry about the tardive akithisia, that drivenness to move especially -- well, especially when they're

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on drugs.
Q. August 22nd, that was the office visit regarding the tongue thrusting, right?
A. Yes, sir.
Q. Then you were asked a question about, well, where did you get the couple-week delay in getting him to see Dr. Segal?
A. Yes. It's from the records.
Q. Maybe from Dr. Segal's own testimony?
A. Yes.
Q. You reviewed his deposition, didn't you?
A. Yes.
MR. MORRISSEY: May I approach, your Honor?
THE COURT: Yes, you may.
BY MR. MORRISSEY:
Q. Can you look at Page 119, Doctor?
A. Okay.
Q. Are you there, Doctor?
A. Yes, I am.
Q. His testimony was that mom had made a phone call to the office alerting Dr. Segal to the tongue thrusting, right?
A. That's right.
Q. My first question is any documentation

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in Dr. Segal's records about the phone call?
A. No.
Q. But he did talk about it in his deposition, didn't he?
A. Yes, he did.
Q. As to the timing, he said you are not -- the question was you are not exactly sure when in time that occurred, meaning the phone call, but you estimated it to be probably late July?
Answer, mid to late July.
Is that right?
A. Yes, sir.
Q. So it's Dr. Segal himself who gave you the timing of the phone call?
A. Yes, sir.
Q. Now, you said it was reasonable to taper the Zyprexa once there was evidence of tongue thrusting. Do you remember that testimony?
A. Yes.
Q. Was it also reasonable to lower the dose and then say give me a call in a couple of weeks?
A. No.
Q. Why not?
A. Well, there was a major dose reduction,

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huge dose reduction. And you can expect catastrophe in the next day or two when you do at that.
Q. So to comply with the standard of care, what did Dr. Segal need to do?
A. Oh, you make a very small reduction unless you are going to put the person in a hospital, which you could also do. Even if you don't work in a hospital, you can have the person admitted. And you make a -- but let's say we are doing it outside, you make small reduction and you tell the mom here is my cell phone and you stay in touch with me and you call me tomorrow or the next day. Anything weird, anything, if your son just starts doing anything out of the ordinary, he gest suicidal, he gets violent, he gets upset, he starts vomiting is one of the things that could happen, you let me know right away. And you stay on top of it, and you don't make a big reduction like that because that is guaranteed to fail. That's going to go nowhere.
Q. When a physician makes a reduction and tapers like that from 30 milligrams down to 15 milligrams, would you expect the patient's

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movements to get worse?
A. Usually you are going to get a worsening of the movements and a worsening of the whole emotional state. Remember, the brain has been accommodating. The brain has been accommodating. You have taken away now 50 percent of what's been pushing the brain down. The brain is like bursting. It's like a pressure cooker.
Q. When Dr. Segal tapered the medication as he did on August 22nd, 2007, did he tell Mrs. Angel, hey, I'm going to lower the dose, but your son is going to get worse before he gets better?
MR. ANDERSON: Objection to the form of the question as to what he was told.
THE COURT: Can you rephrase it?
BY MR. MORRISSEY:
Q. At the August 22nd visit, did Dr. Segal tell mom that when he reduces the meds, the movements are going to get worse?
MR. ANDERSON: Same objection, your Honor.
THE COURT: Overruled.
THE WITNESS: No. There's no evidence he did that.

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BY MR. MORRISSEY:
Q. Did they in fact get worse?
A. Yes.
Q. Lastly, you talked about Paxil and autism and not giving Paxil to an autistic child. Autism for lack of a better word is a social deficit disorder, is it, Doctor?
A. Yes, sir.
Q. So why wouldn't you -- why wouldn't it be prudent to give a child with autism Paxil?
A. Well, if you look at the label for Paxil, it lists a whole bunch of side effects. And it lists again and again and puts it in a medication guide, and it includes disruptive behavior. It includes, you know, losing inhibition. It includes impulsivity. It includes mania, and there's indication he actually got manic, high-like, euphoric on the drug.
So you are giving someone emotional a mostly destabilizing drug. This is a large percentage of the drug that this will happen to who are put on these drugs.
Q. Do autistic children already lack

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inhibition?
A. They can.
Q. Would the drug then aggravate that?
A. It will certainly aggravate it, yes.
MR. MORRISSEY: Thank you, that's all.
THE COURT: Thank you.
Mr. Anderson?
MR. ANDERSON: We are going to get this done in two questions. May I approach?
THE COURT: Yes, you may.
RECROSS-EXAMINATION
BY MR. ANDERSON:
Q. Who started Michael Angel on Paxil?
A. Dr. Klapman.
Q. When?
A. Soon after he came to see him within months as I recall.
Q. Now, you are going to make me ask a third question.
It was January 2002, wasn't it?
A. Okay.
Q. Thank you.
So he would have been on it for about 3 years before he came to see Dr. Segal?

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A. Yes. He was on it for quite awhile.
MR. ANDERSON: Thanks. That is all I have, your Honor.
THE COURT: Any redirect?
REDIRECT EXAMINATION
BY MR. MORRISSEY:
Q. Who continued him on Paxil?
A. Dr. Segal.
Q. Did he have to do that or did he have an independent duty to make his own judgment?
A. Oh, he definitely had an independent duty to make his own judgment and to look back and say disturbed child from when he was first seen. We have never seen him off antidepressants. Every bit of disturbance is in the literature and in the label, literature and label, is being produced by the drug.
A lot of people don't recommend giving these drugs to children, haven't been approved for children. They have been outlawed in Great Britain for children. Let's not do it. Let's take a look if we can get him off slowly.
MR. MORRISSEY: Thank you.
THE COURT: Mr. Anderson?

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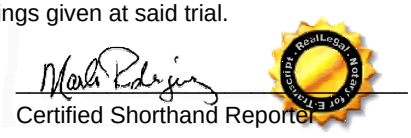
MR. ANDERSON: I guess my standing in the middle of the question ruined it.
RECROSS-EXAMINATION
BY MR. ANDERSON:
Q. By the end of 2005, he got him off Paxil, right?
A. I would have to go back and review. He's off Paxil. He's onto something else.
Q. Not an SSRI?
A. Let me go back and review that with you, sir. It's one of the few things that my memory is not backing me up very well. So by the end of --
Q. By December of 2005, he did manage to get Michael Angel off Paxil, true?
A. Yes. By August of 2005.
MR. ANDERSON: That's all I have. Thank you.
THE COURT: Mr. Morrissey?
MR. MORRISSEY: Nothing, your Honor.
THE COURT: Doctor, you may step down.
(Witness excused.)
THE COURT: Ladies and gentlemen, we are finished for the day. We will start up again at 9:30 tomorrow providing that everyone gets here

safely and that the transportation works sufficiently. Hopefully it will. And again, do not discuss this case with anyone. Do not do any internet research, Facebook, Twitter, blogging, all of that jazz regarding your jury service or the parties, lawyers, witnesses, the medical issues, any aspect of the case, and have a good evening and safe trip home.

(Whereupon, further proceedings in said cause were adjourned to February 7, 2014 at the hour of 9:30 a.m.)

STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)

Marlo Rodriguez, being first duly sworn, on oath says that she is a court reporter doing business in the City of Chicago; and that she reported in shorthand the excerpt proceedings of said trial, and that the foregoing is a true and correct transcript of her shorthand notes so taken as aforesaid, and contains the excerpt proceedings given at said trial.



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