Jeffrey A. Sugar, MD

Diplomate: American Board of Psychiatry and Neurology
In both General and Child and Adolescent Psychiatry, 1991

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DECLARATION OF JEFFREY A. SUGAR, M.D.

[This version for informative purposes only—please do not complete.]

I, Jeffrey A. Sugar, M.D. declare as follows:

1. I am a physician licensed to practice medicine in the State of California. I have personal knowledge of all of the following facts, and if called to testify in court, could and would testify competently to these facts.

2. I am a psychiatrist, Board certified by the American Board of Psychiatry and Neurology both in General Psychiatry and in Child and Adolescent Psychiatry. I received my BA degree from New College in Sarasota, Florida in 1976 and my M.D. degree from University of California, San Francisco School of Medicine in 1984. I completed a psychiatric internship and residency at Harbor-UCLA Medical Center in 1987 and a fellowship in child psychiatry at UCLA in 1989 where I also served on clinical faculty. I am presently Assistant Professor of Clinical Psychiatry at the University of Southern California. I am a past president of the Southern California Society of Child and Adolescent Psychiatry and a Distinguished Life Fellow of the American Psychiatric Association.

3. I have been retained by_____, the attorneys for_____in the case of _____v. _____ Ihave been asked to evaluate the emotional damages sustained by_____ as set forth in the complaint filed in this case.

4. To properly assess the psychiatric damages claimed, and to evaluate the causes and extent of these damages, I conduct a thorough psychiatric examination of each plaintiff. This examination consists of a clinical psychiatric interview: personal and social history; educational and work history; medical history; review of current psychiatric symptoms. Personal and social history includes family and childhood experience, such as development, legal involvement, friends and romantic interests, educational history, work history and other aspects of interpersonal or institutional experience. This historical information is *in addition to* an evaluation of the events that the plaintiff asserts to be the cause of the alleged psychiatric damages. The interview includes a detailed Mental Status Examination. This is the psychiatric equivalent of an internist's Physical Examination and provides a comprehensive view of the plaintiff's *current mental state* including appearance, attitude and behavior, speech, thinking content and process, affect, mood, orientation, immediate, short-term and long-term memory, impulse control, insight and judgment, abstract thinking including wishes and visualization, and other mental functions.

5. Time for the interview is minimally six hours. Breaks for meals, personal comfort or necessity may be taken as needed. In some cases, because of the complexity of the history or issues, or because of communication problems, including reluctance of some individuals to speak to someone unknown to them, *the exam might require more time*; or for various reasons, the sessions may need to be shortened. In those cases, a second or even a third interview session could be required.

6. If the plaintiff is a child, or if an assessment is being made related to an event that occurred when the plaintiff was a child, it is best to interview a caregiver. This is because a child may not reasonably be expected to report the history of his/her development or the outward manifestations of his/her own thinking, feeling and behavior. For younger children, this caregiver interview may last longer than the interview of the child. Note that, depending on life circumstances, 18 to 24+ year-olds, while legally adults, are still functionally more like children, as the brain continues to mature into the early 30s. Often with these "transitional-age" youth, a caregiver interview is also most beneficial.

7. The examination normally consists entirely of the clinical interview. No invasive or physical examinations will be performed. On occasion I may ask the examinee or his or her guardian to complete one or more standardized rating scales to help with my assessment (see item 8 below). I sometimes ask plaintiffs to draw one or more pictures, or to engage in a mutual drawing game called "Squiggle," both as a way to engage attention and as a vehicle for discussion. All these additional measures may help with *my* assessment process and do *not* substitute for more comprehensive psychological testing if such testing is indicated (see item 9 below).

8. In cases involving reactions to trauma, I may use the Trauma Symptom Checklist for Children (TSC-C) the Trauma Symptom Checklist for Young Children, (TSC-YC) or for plaintiffs over 18, I may use the Trauma Symptom Inventory-2. To assess Depression, I may use the Children's Depression Rating Scale (CRDS) or the Children's Depression Inventory (CDI) for children. Over 18, I may use the Hamilton Depression Rating Scale or the Beck Depression Inventory II (BDI II). To assess Anxiety, I may use the Screen for Child Anxiety and Related Disorders (SCARED) for children, or the Adult Manifest Anxiety Scale (AMAS) over 18. For ADHD evaluations, I use validated Parent and Teacher rating scales for children and Adult ADHD rating scales for adults. Other validated scales may be used, depending on the alleged symptoms and the client's presentation at the time of the exam.

9. In some cases, such as those requiring a detailed assessment of Traumatic Brain Injury, Learning Problems or Intellectual Disability, psychological testing is often indicated. Therefore, if I determine that such testing would be helpful, I may recommend that, in *addition* to my evaluation, specific testing be performed by a Licensed Clinical Psychologist or Neuropsychologist.

I declare under penalty of perjury that the foregoing is true and correct.

Executed_____20_____at El Segundo, California.

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Jeffrey A. Sugar, M.D