June 2, 2000
1668 Trumansburg Rd.
Ithaca, NY 14850

bonze blayk 2014.02.15 07:27:59 -05'00'

From: Kevin Eric Saunders a/k/a bonze blayk

To Whom It May Concern:

This letter provides comments on some of the most prominent errors in the reports prepared by the psychiatrists who conducted my psychiatric examinations at the Rochester Regional Forensic Unit, and conveys my current understanding of the cause of the major physical and psychiatric illness that underlay the arson offense of 2/6/97, which led to my plea of Not Responsible by Reason of Mental Disease or Disorder [sic: Defect], accepted by the Court, and my current Order of Conditions.

In general, the reports prepared by Dr. Kennedy and Dr. Singh of the Rochester Regional Forensic Unit have a tendency to interpret my character and history in a negative light, and contain many errors of fact and interpretation, some provably false. In addition, they signally failed to adequately consider the evidence that medical, rather than characterological, problems caused the psychotic state in which I committed the arson offense of 2/6/97. To summarize:

1) A long history of violent behaviors and unstable relationships was incorrectly attributed to me.

2) My employment history at Cornell University was distorted.

3) "Cannabis Abuse" was simply assumed as a diagnosis, without genuine evidence of harm, and indications of "Cannabis Dependence" were invented.

4) Relevant medical records from my primary health care providers were neither obtained nor reviewed. The possibility of adverse reactions to Prozac (Fluoxetine) and/or Trazodone were not considered.

The last point is of major significance.

I will discuss these points in more detail:

1) A long history of violent behavior and unstable relationships was incorrectly attributed to me.

The RRFU reports indicate that I am disposed to violent behavior; this claim is based primarily on statements and accusations made by Susan Hamann, and no significant attempts were made to confirm that her statements were reliable. No other person with whom I have had a close relationship was interviewed, including my mother, my brother, my friend and former lover Mia Merywether Finkeldey, and especially my former wife of 14 years, AnneMarie Whelan. Ms. Whelan would have contradicted the unsubstantiated allegation cited by Dr. Kennedy (p.6): "An interview with Susan Hamann, an ex-girlfriend who was a worker in a battered women's shelter, revealed that there is history of alleged physical abuse of Ms. Whelan for approximately 14 years." No source for this allegation is cited, which Ms. Hamann merely reports without affirming its truth.

I have provided a relationship history to Linda Riley, C.S.W, which helps correct the record in respect to the duration and character of my romantic and family relationships.

2) My employment history at Cornell was distorted.

My history as a computer systems professional at Cornell is portrayed in a negative light. In fact I received a 60% raise in real terms over 7 1/2 [sic: 8 1/4] years working on network systems [see attached]. After leaving my position in January 1994 I maintained an excellent working relationship with the same management at Cornell as both a contractor and licensee to a software property of Cornell (Comet/dataComet) which is still widely distributed at Cornell.

To provide an example of a major error in my history, regarding both my employment and therapeutic records:

> "Mr. Saunders next received 12 sessions of counseling in 1990 at Cornell Employee Assistance Program. The records from this counseling session are not available. Mr. Saunders reported that he was referred to the EAP due to his conflict with his supervisor. In our records, we have a letter from Eric Saunders to David Lambert, Director CID/Network Resources [sic: CIT], dated 11/15/90 in which he had complained about his supervisor to the director." (Dr. Singh, p.5)

Records from these counseling sessions are not available because they never took place; the only source for this assertion was an error I made in dating the single referral to EAP in my treatment history summary (2/90 rather than 2/92), an error which I reported while I was examined at the RRFU.

Note that I was not disciplined for the letter to which Dr. Singh refers; to the contrary, Mr. Lambert recognized that I had legitimate complaints, and I received a substantial raise, along with the promise that I would soon receive a promotion up two grades in recognition of my achievement in managing the design, programming, and distribution of Comet. [see attached]

Dr. Singh also made an interpretation which is startling in its incongruence with the source document:

> "The letters also contain some grandiosity. For example, at one place Mr. Saunders states I'm trying to show them that I'm brilliant, that I have the correct answers, and that they're all fools if they disagree with me--which seems to be the traditional CCS/CID [sic: CIT] attitude.'" (Dr. Singh, p.5)

This statement is quite clear in the original: I am condemning a contemptuous attitude toward customers which is, unfortunately, fairly common among computer systems specialists. [see attached]

It should be noted that after the referral in 1992, I returned to work in the same department under the same higher management, in a position with similar responsibilities, and continued to work in this position for two years before leaving Cornell, when I could have been fired at will with no repercussions--except the loss of my valuable network systems expertise.

These negative interpretations seem to be strongly influenced by the assumption that a self-avowed self-medicating marijuana user simply could not function successfully as a self-educated professional at a top-ranked academic research institution in a challenging, highly technical field--an assumption which is belied by the facts.

3) "Cannabis Abuse" was simply assumed as a diagnosis, without genuine evidence of harm, and indications of "Cannabis Dependence" were invented.

Dr. Singh and Dr. Kennedy both engage in the logical fallacy of begging

the question (*petitio principii*) in evaluating my use of marijuana and concluding that I suffer from "Cannabis Dependence." I have always contended that my use of cannabis has been, overall, beneficial for my functioning and my state of mind. Dr. Singh and Dr. Kennedy repeatedly refer to *abuse* rather than *use,* without establishing that my use is harmful; from this starting point they proceed inexorably to the conclusion that my regular use of marijuana is maladaptive and must qualify as dependence, resorting to invention to note "withdrawal symptoms" and "use of alcohol ... to relieve or avoid withdrawal symptoms," assuming negative consequences which I have never suffered, and ignoring the substantial benefits in improved mood, focus, and concentration which are noted repeatedly in my statements in the therapeutic record.

It is especially noteworthy that Dr. Singh and Dr. Kennedy contradict each other on the facts regarding the single urine sample taken after my admission for the mental examination at the RRFU:

> **"He was found positive on initial tox urine for cannabinoid 20 and 100 strengths." (Dr. Singh, p.14)**
>
> **"His toxicology screens were negative for marijuana." (Dr. Kennedy p.15)**

This "positive" urine test was used as a basis for petitioning the court to extend my one month inpatient examination for an additional month.

One notable truth, which is that I've never lied to anyone regarding my use of marijuana, goes unremarked. My use over 7 1/2 years [sic: 8 1/4 years] of working at Cornell as a reasonably well-paid professional in a highly responsible position was never noticed, because moderate use of cannabis does not induce a state of intoxication. I'm not proud of my use of marijuana; nor am I ashamed of this use; the truth is that it helps me function better, especially in my capacity as a computer programmer, and if it didn't, I would never have used it on a regular basis. (The notion that I sought to justify my use as a remedy for neurological and/or autoimmune diseases is incorrect: I was *afraid* that the anticonvulsant and/or immunosuppressant effects of cannabis explained why regular use worked well for me, when regular use is not beneficial for most people.)

4) Relevant medical records from my primary health care providers were neither obtained nor reviewed. The possibility of adverse reactions to Prozac (Fluoxetine) and/or Trazodone were not considered.

Finally, the reports conclude that the prolonged illness from which I suffered from early January through February were symptomatic of borderline psychotic states--rather than having an organic cause--without carefully examining my records and considering all possible causes for the illness.

My records from Family Medicine Associates, my primary health care providers for 16 years prior to the offense, were never obtained, even though I provided a release for these records. Drs. Breiman and Shallish of the FMA were my only GPs over this period.

The only record from Dr. Breiman consists of a letter to Dr. Tawil of Strong Memorial Hospital; although I've been told the letter states that "this patient has a long history of somatic preoccupation," I am certain that this is incorrect, without seeing the letter: Dr. Breiman was willing to make a referral, despite the fact that Dr. Stackman had found no neurological basis for my complaints, because his experience was that "this patient has a long history of somatic *complaints,*" that is, complaints about diagnosable somatic illnesses, rather than psychosomatic complaints.

The distressing physical symptoms I suffered over the month of January 1997 preceding the arson offense were dismissed as psychosomatic complaints, without considering the possibility of an adverse reaction to Prozac (Fluoxetine) and/or Trazodone.

Their assessment, and that of the neurologists who examined me, is correct in part: the physical symptoms of numbness and pronounced paresthesias in my limbs, balance difficulties, vision disturbances, and confusion that I had suffered were not caused, as I believed, by the outbreak of an autoimmune disease, e.g., Guillain-Barre Syndrome, or a Chronic Relapsing Polyneuropathy.

And again, the symptoms of a schizophreniform disorder, including major delusions, clinical paranoia, and hallucinations, which I experienced throughout this period to varying degrees, were not manifestations of an inter-ictal psychosis related to epilepsy. The 3-day sleep-deprived EEG testing performed at Strong Memorial is good evidence that I do not suffer from any form of epilepsy.

I was wrong in believing that these were the causes of my illness; however, these were the only reasonable explanations I had for the most frightening physical illness and mental states I have ever experienced. I've endured periods of much greater stress than I was under in January 1997, and have never suffered symptoms of this nature.

The cause of my illness, both physical and mental, is now reasonably clear to me.

First... the medical records which were not reviewed contain the notable fact that I had a rash diagnosed by Dr. Breiman on 1/22/97. The first intimation I had that this was relevant to my illness was in September 1999, when I noted the prominent warning on the bottom of a box of tissues promoting the use of Prozac, which was displayed in the offices of the Tompkins County Mental Health clinic:

> "Discontinue immediately if rash or other possibly allergic phenomena appear for which an alternative etiology can not be determined."

At that time I began to suspect that Prozac was involved in my illness; why should an adverse reaction experienced by 4% of patients in the clinical trials require immediate discontinuation of use, when Fluoxetine is remarkably non-toxic? However, the mechanisms involved were unclear, and provided an unsatisfactory explanation for the range and scope of my symptoms.

In May 2000, I finally began to put the facts together. I assembled a chronology of the events of January 1997, using my health and personal records, and reconstructed my web access history over that month. This chronology aligned well with established medical facts:

> Prozac can cause paresthesias (a fact noted by Dr. Stackman). Likewise, Trazodone can cause numbness. This is because Fluoxetine and Trazodone are potent sodium channel blockers. In fact, Trazodone is an anti-neuralgic, and this effect was an important consideration in the design of this drug.

The heart arrhythmia and peripheral numbness which led me to seek help at the Tompkins County Emergency Room on 1/11/97 had been caused by my ingestion of 275 mg. of Trazodone over 6 days. Sensation lost during the night after taking Trazodone would return to my arms and legs after rubbing them--because this mechanically displaced the molecules from their blockade of sodium channels.

I examined the monograph on Trazodone thoroughly, and research on its mode of action and side effects established that:

> The primary metabolite of Trazodone is the substance mCPP (meta-chlorophenylpiperazine, or 1-(3-Chlorophenyl)piperazine). About 48% of Trazodone is metabolized to mCPP; mCPP is a potent anxiogenic agent, which is known to induce depersonalization, and which also possesses hallucinogenic properties. Usually the positive effects of the parent substance, Trazodone, overbalance the negative effects of mCPP, so that delirium induced by Trazodone is rare... but it does occur.

The fear and growing paranoia I experienced some days prior to going to the hospital, including the experience of a terrifying waking-dream state with prominent visual images, were caused by mCPP intoxication. (The schizophreniform features of the psychosis from which I suffered over January were probably aggravated by the interaction of mCPP and Fluoxetine, which boosts dopamine levels in the prefrontal cortex and other areas of the brain, even as it raises the reward threshold in the mesolimbic system.)

The rapidly growing rash on my groin (1/22/97) was probably caused by toxins passing into bile which would ordinarily be metabolized prior to excretion. Why? Because Prozac selectively impairs metabolic function:

> Fluoxetine's primary active metabolite, Norfluoxetine, strongly inhibits the function of the CYP3A4 enzyme, which also metabolizes Trazodone to mCPP. Moreover, both Fluoxetine and Norfluoxetine potently inhibit the function of the CYP2D6 enzyme... which is also the only metabolic pathway for the degradation of mCPP. mCPP is lipid soluble (log P = 2.11) and has a low molecular weight (196) and so will be excreted slowly under favorable conditions...

My excretion of mCPP would clearly have been greatly prolonged, since I was suffering from urinary retention, constipation, and hypophagia caused by Fluoxetine, Trazodone and mCPP (which is also a potent anorectic agent).

At the time I committed the arson, on the morning of 2/6/97, I was in a state of panic and experienced auditory hallucinations which recurred over the two following nights. The panic and hallucinations were caused by mCPP.

I have provided a summary along with abstracts on these scientific findings on the effects of Fluoxetine, Trazodone, and mCPP. The symptoms I reported to various physicians in January 1997, and stated in my "Medical History and Recent Physical and Psychological Symptomatology, 4/28/97" are all explained, in the simplest, most direct interpretation, as known adverse side effects of the medications I was prescribed.

At this time, I can now confidently affirm what I could not at the time of my first interview on 11/4/97 with Dr. Singh: "The psychosis which led me to commit the arson on 2/6/97, in a state of mind in which I was not criminally responsible for my actions, **will not happen again**--because an intoxicating byproduct of psychiatric medications was the cause of the psychosis, rather than endogenous factors."

Sincerely,

Kevin Eric Saunders a/k/a bonze blayk

Kevin Eric Saunders a/k/a bonze blayk

Pay History -- Network Systems Programming and Support (4/29/00)

Cornell University (COMET, OmniTalk, Mac EZ-REMOTE, backline support)

Date	Yearly	Hrs.	FTEquiv.	Status	Raise %	Reason
7/11/85	7,600	19	15,600	Casual		Hired at $8.00/hr
11/12/85	8,075	19	16,575			Raise to $8.50/hr
5/ 8/86	10,750	20	20,962	1/2 FTE	26.0	Promotion, Salaried Emp.
4/23/87	16,125	30	20,962	3/4 FTE		Increase in hours
7/ 2/87	16,995	30	22,093		5.4	SIP Raise
12/ 3/87	22,660	39	22,660	1 FTE		Increase in hours
12/31/87	23,744	39	23,744		7.5	Merit Raise
7/ 2/88	25,700	39	25,700		8.2	SIP Raise
6/29/89	26,700	39	26,700		3.9	SIP Raise
6/28/90	27,768	39	27,768		4.0	SIP Raise
2/ 1/91	16,514	20	32,202	1/2 FTE	16.0	Merit Raise
6/27/91	17,175	20	33,491		4.0	SIP Raise
6/28/92	17,690	20	34,495		3.0	SIP Raise
6/28/93	18,176	20	35,445		2.7	SIP Raise
8/ 1/93	35,445	39	35,445	1 FTE		Returned to fulltime
3/ 3/94	35,445	39	35,445	1 FTE		Quit Cornell; offered promotion and $40,000 by David Lambert (13%)

Millennium Computer Corporation, Rochester (MAP & COMET)

2/14/94	55,000	40	55,000	1 FTE	55.2	New Salary
9/ 1/94						Quit Millennium

databeast, Inc.: Cornell Purchase Orders filled:

1/10/95	1,755	COMET (No POs could be filed until databeast was incorporated;
2/ 3/95	1,665	COMET after 5/1/95, all work on dataComet was free for Cornell;
3/10/95	607	COMET PowerPC and Kerberos support were required by license.)
9/20/95	1,800	Image Lab
12/19/95	1,800	Image Lab
3/26/96	1,100	Image Lab
7/10/96	1,600	Image Lab
10/10/96	2,700	Mann Library
10/10/96	800	Image Lab
1/13/97	960	Image Lab (for work done 11/96-12/96)
	14,787	

9/94 - 4/95	COMET	$45/hr
5/95 - 3/97	dataComet $20,000 blanket order required in dataComet license	$45/hr
8/95 - 5/97	Vet School Image Lab (Barbara Tefft) Custom-built WebStar/Applescript Order Entry Web Server	$50/hr
10/96 - 1/97	Mann Library (Tim Lynch) Implementation of billing system for printing services would have taken about 400 additional hours, with more followon work	$27/hr

SIP - Salary Increase Program at Cornell, regular yearly salary adjustments
"Casual" appointments at Cornell are made for temporary employees, who do not receive benefits, and are limited to less than 19 hours per week of work.

PSYCHIATRIC HISTORY: Mr. Saunders reported that he had his first psychiatric therapy in 1988 when he went to see a counselor at Family and Childrens Service in Ithaca. One of his female friends believed that he was depressed and had suggested that he should seek therapy. Mr. Saunders went for counseling only three or four times and then stopped as he did not believe that counseling was helpful. He was not prescribed any medications. Mr. Saunders reported that he stopped the therapy because "The guy had nothing to offer, he was challenging and annoying." Mr. Saunders next received 12 sessions of counseling in 1990 at Cornell Employee Assistance Program. The records from this counseling session are not available. Mr. Saunders reported that he was referred to the EAP due to his conflict with his supervisor. In our records, we have a letter from Eric Saunders to David Lambert, Director CID/Network Resources, dated 11/15/90 in which he had complained about his supervisor to the director.

Mr. Saunders was referred back to EAP in 1992 at Cornell where he was seen from 1/29/92 until 6/11/92. This referral once again was due to his conflict at work. In January 1992, he had sent numerous E-mail messages to his supervisors complaining about his dissatisfaction with the work, chiefly about his compensation and lack of satisfaction with the team he was working with. His E-mails are notable for him planning to make a career in "show biz." These letters are somewhat rambling and show some disorganization of his thought process. The letters also contain some grandiosity. For example, at one place Mr. Saunders states "I'm trying to show them that I'm brilliant, that I have the correct answers, and that they're all fools if they disagree with me--which seems to be the traditional CCS/CID attitude." It is difficult to comment whether this is baseline for Mr. Saunders or there was a change in his thought organization and contents. In a memo dated 1/21/92, Mr. Saunders writes "it's better to do some work rather than be upset--when you wake up at 2:30 and can't get to sleep because your job situation is bugging you." At some point around this period, prior to him being referred to EAP, he allegedly had made some threats to introduce a virus to the program but this situation is not clear. The progress notes from the EAP encounter reveal the following: "client attended sessions because Cornell University requested he do so, very cooperative, told story in great detail; sees mother as the authority linked to situation at work place, does not see messages on computer as threatening, denies he would ever damage the network; says he would not sabotage program by virus' because it's against his moral standards, feels outraged at being suspected, not being rewarded for his work." During these sessions, there were issues of patient not being accepted by his mother which came up as a therapeutic issue. There was also a quote about this problem which said "realized he had internalized mother-voice, 'I'm stupid--an idiot'. Kevin and mom had permeable boundary." Patient's case was closed on 6/11/92 and he was

* * * Top of File * * *
Date: Thu, 16 Jan 92 19:42:14 EST
From: Kevin Saunders <CQU@CORNELLC>
Subject: Shapes of Things
To: Dick Cogger <RHX@CORNELLC>,
dave lambert <hdl@cornella>,
msl@cornella
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Thanks. Show business has no idea what's on the way...

As for my "idea of how an organization should treat me", I'd expect at a minimum that an organization should abide by its own published standards... check 'em out sometime. Personnel Manual #201, Administering Wages and Salaries, delineates a number of standards and policy goals... which you have repeatedly told me are real howlers. I, however, take enunciated organizational values VERY seriously, and I intend to hold Cornell to them, whether you accept them or not, whether you believe they are simply a joke Personnel plays on us or not. Dave's "Network Resources Organizational Values" are pertinent also:
"10) Relations among the staff of Network Resources should be characterized by *respect*, helpfulness, sharing, tolerance, forgiveness, openness, honesty, and (above all) good humor."
The emphasis is mine, and I think that value does belong first.

It's weird--I get so much positive feedback from Comet users, when at last I bother to ask them to help *me* out... "Comet is the best product offered by CIT." And they don't understand why *I'm* not valued... maybe they feel that way because I try to *show* respect for them and try to meet their felt needs, rather than trying to show them that I am brilliant, that I have the correct answers, and that they're all fools if they disagree with me--which seems to be the traditional CCS/CIT attitude. Or maybe they feel that way because it's a fine product, which embodies the way that I care about them, and that I share their feelings about the importance of *their* work and *their* need to communicate--*efficiently*. If IR happens to originate a good idea that users like, I'll adopt it. If the non-standard position of the Reset menu-key gives Tom Young the hives, I'll change it. And when bugs crop up, I do my best to fix them, and Comet users *know it.*

You oughta haul that copy of Gerald Weinberg's "Psychology of Computer Programming" down from your bookshelf and *read it*. I suggested to Dave that he do so also. Fred Brooks' "The Mythical Man-Month" might also help enlighten you on the reasoning behind the UNIVERSAL response to bringing on Gimbrone: You CAN'T speed up a car by adding cylinders that DON'T FIRE! Gimbrone is a proven *disaster* with modems...

But hey, I'm willing to work with Dimock, even if I *do* believe he is an *immoralist*... as for incompetence, as I told Bill

Turner the other day, if you don't reach your level of incompetence in this business... you're not trying.
My last-straw feeling derives not so much from having to work with Nick as the WAY the decision was made, in complete disregard of the desires of the ENTIRE NR-Tech staff:

If you won't take no for an answer, don't bother asking.

Anyway...

I'm perfectly willing to make a meeting with *everybody* who's supposed to work on this thing. Porting the router should be a piece of cake (~ 1 month FTE--remember, I did the same for the foreground-only MacBridge...). The MacBridge is slightly hairier... as I had mentioned B.G. (Before Gimbrone) I made progress in November towards cleaning up the assembly-language LAP interface so it called C routines, which use code adapted from Comet.
This will of course greatly ease migration to future interfaces... PPP will provide automatic net/node # negotiation, so users will need only to enter a valid password for the Annex server to approve; the server can then communicate the net # to the MacBridge (net/node negotiation is defined in the current PPP standard).

Of course, the Annex PPP implementation has to work correctly. If we can lift the PPP negotiation stuff from the Annex implmentation, that'll speed up work on the Mac end correspondingly.

And finally...
My goal here is not to screw Cornell: it's to arrange a fair divorce settlement. Divorce does not *have* to be hell... but it usually is, if the parties do not divide jointly-produced assets in an equitable manner. Comet is an helluva asset: the basic concept is your *idea*, but the blood, sweat, and yes, tears, are mine.

"To hold it upright and fill it,
Is not so good as stopping in time.
When you pound it out and give it a point,
It won't be preserved very long.
When gold and jade fill your rooms,
You'll never be able to protect them.
Arrogance and pride with wealth and rank,
On their own bring on disaster.
When the deed is accomplished you retire;
Such is Heaven's Way!"
-- Te-Tao Ching, Lao Tzu (Trans. Robert G Henricks)

Date: Thu, 16 Jan 92 14:13:45 EST
From: Dick Cogger <RHX@CORNELLC>
Subject: Re: Things
To: Kevin Saunders <CQU@CORNELLC>
cc: Dave Lambert <hdl@cornella>

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Kevin, glad to hear that show-biz is opening up for you-- I have to doubt that Cornell could ever match up to your idea of how an organization should treat you over the long run. But as you're dealing with Dave and Stuart, there's probably not a lot for me to do, at least until you have things worked out at that level. If there is something you want me to do, let me know.

My assumption would be that whatever is to be worked out won't happen instantly or even within days, so what's your idea of what you and I should do in the meantime? I agree with your assessment that the right direction is appletalk over ppp and the corresponding macbridge implementation. Are you willing to participate in discussions with the team (or part of it)? Or do you think that's inappropriate until the other issues are resolved? My concern is that if we don't have a plan and functional spec documented in the next couple weeks, Xylogics will kiss us off. Then we may see ARA go the way of quickmail.

If I don't respond to all the points you raise, don't think I'm ignoring them. We can discuss, if you like, when there's time.

-Dick

* * * End of File * * *

...NELL
VERSITY

Cornell Information Technologies
Network Resources Division
Technologies
143A Caldwell Hall

Date: Wednesday, February 13, 1991

To: H. David Lambert

From: Richard Cogger

Subject: Reclassification and Salary program for Kevin Saunders

This memorandum recommends a raise and eventual reclassification for Kevin Saunders in recognition of major changes in the nature, scope, and level of his job duties over the past two years. I would be recommending a reclassification at this time but understand there is a freeze in effect now. It is also the case that Kevin has been able to rise to these new requirements, expanding his scope and accepting greater responsibility.

Probably, Kevin should have received a reclassification some time ago, but the value and level of technical work is not always immediately evident. In my experience, it is a common occurrence for a programmer in the early years of his career to work along, making progress but not able to do really outstanding work until a certain point. At such a point, accumulated experience allows the person to "put it all together," to produce a major achievement. Kevin first reached that point in the fall of 1988 on the Omnitalk project, but various outside considerations resulted in this work not being used, so Kevin did not receive the general recognition he merited. Kevin reached a further level in synthesizing an important result this past July and August when he forged the Comet Terminal Emulator program from a number of components he had been working on previously. Fortunately, this work is being generally released and not only demonstrates Kevin's ability but will serve to establish his reputation in the networking community as well as at Cornell. Beyond the level of technical work required, in bringing this product out, it was necessary for Kevin to perform a complex series of co-ordinations and deal with a level of administrative and other interactions beyond what is usual at his current level.

Kevin has also requested that his position be returned to half-time (20 hrs./wk instead of 39), as it was prior to January of 1988. Although I

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believe he would make faster progress professionally working full time, I understand that he has personal reasons for limiting his commitment to part time. At this point, Kevin has raised his level of contribution substantially and can, in my opinion, go on to broaden his capability at a fair rate over the next two years, even working part time.

Kevin is currently classified at level 34, Systems Programmer III, within the current technical job classification system. His current salary is $27,768. He has now over 5 years experience I believe his current classification and salary levels were somewhat below what they should have been as of a year ago, for his general experience and capabilities, and the disparity is now substantial, given the level at which he has been working during the past year and more.

I believe that Kevin should now be classified as Tech Specialist I at grade 36. His salary should be approaching the mid thirties (in full-time terms) and be above the mid thirties a year from now.

Anticipating that it may be difficult to bring Kevin all the way to where he should be in a single step, I propose a program aimed at moving him to the proper level over the next 18 months. I believe that a significant salary increment will be an appropriate first step. With a normal merit raise in July, an additional mid-year increment a year from now should bring him almost to the level where he should be. In the course of the classification study, his level will be considered, and I believe a reclassification to level 36 will turn out to be appropriate.

I'm not sure exactly what effect the new system being piloted in CIT will have, but I believe this recommendation is compatible with both the current system and the new one. Accordingly I propose the following program:

1. Effective 2-1-91 (or as soon as processing can be completed):

   Raise approx. 16% to $32,200 ($16.514 at 20/39 time)
   Reduce to 20 hr/wk.

2. Effective 7-1-91:

   Raise approx. 5% to $33,800 ($17,333 at 20/39 time)
   (assumed normal SIP increment)

3. Effective with the completion of the classification study:

Reclass to Tech Specialist I, level 36 — Not Done.

4. Effective 1-1-92:

Raise approx 10% to $37,200 ($19.077 at 20/39 time) — Not Done.

Naturally, steps 2., 3, and 4. cannot be committed at this time, but represent a plan and an expectation, contingent on performance, results of the classification study, and on other factors, of what will be necessary to fairly recognize this valuable employee's advancing job level, capabilities, and contributions.

Attached is a proposed job description to describe the changed position proposed for Kevin.

were purely subjective and there was no objective neurological deficit. In spite of these complaints, there was no clear symptoms of psychosis or mood disorder and he continued to be pleasant and cooperative. He spent his time usually watching television or reading books and newspapers.

Patient underwent a 72 hour EEG monitoring at the Comprehensive Epilepsy Program at the University of Rochester. There was no electrical seizure noted during this observation. Patient was found to have thrashing movements of his body which he called as seizures and these were labeled as pseudoseizures. He also underwent a routine EEG test on 2/11/98 which showed "mildly abnormal EEG because of occasional left temporal slowing seen best in drowsiness. This finding can suggest a functional or structural abnormality involving the same region."

In the latter part of the hospitalization, patient became much more assertive and demanding. He also became more critical of others, especially the staff members. This was attributable to his personality style rather than major mental illness.

Admission physical examination revealed psoriasis of the scalp. His admission labs, including RPR and TFT's were normal. He was found positive on initial tox urine for cannabinoid 20 and 100 strengths.

MENTAL STATUS EXAMINATION: Mr. Saunders is a short statured, white male who has long hair. He maintains good personal hygiene and dresses casually in a shirt and jeans. He is fully alert and oriented. There is no evidence of any abnormal motor movements. His speech is of normal rate and rhythm. His speech is characteristic for him saying "uh" at end of sentences. He is usually pleasant and cooperative but does tend to take an assertive approach during interviews. He often throws out his own diagnoses and minimizes others' assessment of him from the past. He also shows a generalized tendency to blame others for the problems from the past. His mood is euthymic and his affect is of full range and appropriate. His thought flow is mildly increased with extreme circumstantiality but there is no evidence of pressure of speech or flight of ideas. There is no evidence of delusions, preoccupations or hallucinations. There is no perceptual abnormality. His cognitive examination reveals above average intelligence, good memory functions and good abstraction. His judgment usually is good. His insight is influenced by his preoccupation with his various somatic complaints and the diagnoses he has made for himself.

During our interviews, when asked about his problems, patient responded "I might have a mental illness but I'm capable of functioning as an outpatient." When asked about his mental

EXAMINATION ON THE ROCHESTER REGIONAL FORENSIC UNIT:

Mr. Saunders took the bus from Ithaca to be admitted in late January to the RRFU. He was noted to eat and sleep well throughout his stay. There were no symptoms of depression, mania, or psychosis. In addition, there were no panic attacks or anxiety symptoms. His toxicology screens were negative for marijuana. He did have an episode where he was sleeping and awoke with a squeal. He called nursing staff to see him, stating he was having neurologic symptoms, perhaps of a seizure disorder. In fact, what he had done was sleep on his one arm folded. He had numbness and tingling in his fourth and fifth digits and hypothenar eminence, which resolved within a minute. This is entirely consistent with ulnar nerve compression secondary to sleeping on his arm; in layman's terms, his hand was asleep. This was noted as indicative of over-reporting of symptoms. Mr. Saunders was noted to cling tightly to the notion that he had a demyelinating polyneuropathy and was quite upset when told that we would not do any further testing of it and stated, "don't worry, I'm going to go to court and claim that I have a polyneuropathy and that you've done nothing to test for it."

DIAGNOSIS:

Mr. Saunders currently suffers from the following mental illnesses:

1. Borderline Personality Disorder. Mr. Saunders makes significant efforts to avoid real or imagined abandonment. He has a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. He has had a markedly unstable self-image or sense of self given his identity disturbance of gender. Although he has not had recurrent suicidal behavior, gestures, or threats, he has had chronic suicidal ideation. He has had an affective instability due to a marked reactivity of mood. There have been chronic feelings of emptiness. He has had inappropriate, intense anger or difficulty controlling anger. He has transient stress related paranoid ideation in a severe dissociation of symptoms.

2. Marijuana Dependence. Mr. Saunders has had characteristic withdrawal symptoms from marijuana and he has taken a closely related substance, namely alcohol, to relieve or avoid withdrawal symptoms. He has had unsuccessful efforts to cut down or control his substance abuse. His occupational and interpersonal activities have been reduced because of substance abuse and the substance use has continued in spite of knowledge of having a persistent recurrent physical or psychological problems, which has likely been caused or exacerbation by the substance.