"You can't solve a problem unless you diagnose it." -- George W. Bush
"Diagnosis doesn't matter" -- Amari Meader

1) Pharmacological ignorance (couldn't spot the hallucinogen)

"Magic Bullets" are not suspect in cases of harm.
Nicotine Dependence doesn't exist.
Cannabis Use == Intoxication == Abuse == Dependence

Splitting: a manifestation of borderline reality testing

2) Incompetence in observation
3) Incompetence in managing communications

GIGO: pattern of misquotations and factual errors
apparently no procedures for noting or correcting errors

4) Presumption of client incompetence

WRT voting rights, sharing my house, travel, and
indeed personal sensations of physical discomfort--
"Undifferentiated Somatoform Disorder"

a) Systematic withholding of information from clients

b) Routine devaluation of client "self-reports" and competence
(not "fair play", not a "level playing field")

— bonus —

descriptive adjectives...

Flaming
hyperbolic
intelligent
sensitive (yet ~~crude~~ crude)
sexual
CUTE!
chaotic good

List of self-descriptive adjectives prepared at Ann Matusewicz' MD's request sometime around August 1993...

Merriam-Webster Collegiate Dictionary
<http://www.m-w.com/cgi-bin/dictionary>

Main Entry: flam·ing
Function: adjective
Date: 14th century
1 : resembling or suggesting a flame in color, brilliance, or wavy outline <the flaming sunset sky> <flaming red hair>
2 : being on fire : BLAZING
3 : INTENSE, PASSIONATE <flaming youth>
4 -- used as an intensive <you flaming idiot>

Main Entry: lhy·per·bol·ic
Function: adjective
Date: 15th century
: of, relating to, or marked by hyperbole [i.e., extravagant exaggeration, see...]

Main Entry: hy·per·bo·le
Function: noun
Etymology: Latin, from Greek hyperbolE excess, hyperbole, hyperbola, from hyperballein to exceed, from hyper- + ballein to throw -- more at DEVIL
Date: 15th century
: extravagant exaggeration (as "mile-high ice-cream cones")

Main Entry: hack·er
Function: noun
Date: 14th century
1 : one that hacks
2 : a person who is inexperienced or unskilled at a particular activity <a tennis hacker>
3 : an expert at programming and solving problems with a computer
4 : a person who illegally gains access to and sometimes tampers with information in a computer system

Frank Kermode *The Sense of An Ending*
Franz Kafka *The Trial*
Umberto Eco *The Name of The Rose, Foucault's Pendulum*
The Holy Bible

I, Anne Rose Blayk, *know* that I am *simultaneously:*

The most articulate living exponent of the philosophy of Ayn Rand ("The Axiom of Non-Aggression")
A Lay Priest of the Church Catholic, with special ordination to perform Latin Rites
A Bonze of the Tibetan Buddhist order
A Taoist, a reincarnation of Lao Tse (et. al.)
A Minister, Disciples of Christ
A Baptist Minister
An officer in the United States Marine Corps
A Rock Star, formerly an Angry Samoan but now turned to a more positive message;
I will play in an all-girl band, with Red Letter also as a backing band.
A cultural conservative

How Can This Be?

By These Signs Ye Shall Know Him:

DATED 2/1/97

Letter sent to Susan K. Hamann RN sometime in January 1998.
— AnneRose Blayk — 9/30/15

Dear Susan...

re: "you were wrong about having Guillain-Barre Syndrome..."

That's not the case, I just haven't found anyone willing to diagnose it.

Here are a few of the citations on Medline regarding links between mycoplasma pneumoniae and autoimmune disorders, including the demyelinating polyneuropathies, which I just found on Saturday 12/13... Note that I almost died in 1972 from mycoplasmic pneumonia, spent a week at home with fevers running to 104 degrees, then went into the hospital, where a specialist finally diagnosed it correctly and prescribed Erythromycin (which worked where the previous antibiotic did nothing), and then finally returned home after 8 days in the hospital. Most cases of M. Pneumoniae don't even require antibiotics, much less hospitalization, so it's fair to say I had an exceptionally bad case. As I've been saying for practically 12 months now, I recognized my condition last January as one similar to the wasted state I was in after I had pneumonia--which persisted, mirabile dictu, until I started smoking pot in college. (Like my college roommate Jon told me later, the first time they saw me in the dorm I was so skinny and pale they thought I was a junkie.)

Dr. Tawil at Strong Memorial said he "couldn't rule out" chronic immune demyelinating polyneuropathy in my case, in which I was suffering from an ascending paralysis typical of the disease... if, that is, you believe my description of my symptoms. If you look at me as a cannabis-dependent tranvestic nurse-raping arsonist and would-be cop killer--which is the reputation that preceded me--you would probably be inclined to consider seriously the possibility that I was just looking for an excuse and say "this is a case for the psychiatrists" too.

From my research I've discovered that people suffering from CIDP often wait for years and go through several neurologists before receiving a correct diagnosis, because the signs on NCV and EMG tests are sub-clinical--even when the patients can't walk. Patients who receive prednisone sometimes regain functionality almost immediately after administration, just as I started to recover within days after starting to smoke marijuana again. Similar stories of people making dramatic recoveries from MS after starting to smoke marijuana abound... The irony is that the immuno-suppressant properties of marijuana are one of the "dangerous side effects" that the Prohibitionists rant about, so this can be regarded as a widely-acknowledged property of marijuana.

As for TLE, if you go by the clinical psychiatric markers, diagnosing me as a TLE case is a no-brainer. It's not in the DSM because it's an organic and not a "mental illness," and it's become Politically Incorrect since the 60's to acknowledge that many epileptics have nasty psych symptoms. And yes, marijuana is a potent anti-epileptic... according to the sworn testimony of Dr. John Paul Morgan, professor of pharmacology at CUNY Medical School, none of the drugs prescribed to epileptics is as safe or probably as effective as smoked marijuana. A Canadian judge has in the Province of Ontario has just ruled that forbidding epileptics from possessing and smoking marijuana is a violation of their

human rights under their Charter of Rights and Freedoms.

And oh yes, Prozac is such a wonderful drug, my experience of it was even "better" than yours... no anti-epileptic properties, no immunosuppressant properties, and 1% of unipolar depressives became hypomanic in the trials (which excluded those suffering from bipolar illnesses).

I wish I'd spent the $700 I spent on FCS and Fran Markover buying you flowers instead. I'm sorry that I lost my mind, and that I'm fucked up in general, but I'm even sorrier that I trusted those motherfuckers. All I wanted was somebody to talk to who wouldn't gossip... what I got was lies, misdiagnosis, manipulation, and abandonment when I was in the greatest need of support.

Again, please, I acknowledge that I did you grievous harm in the arson... I was "scared out of my wits" and wildly delusional, heard threatening voices on the radio (and believed they were real, having never had auditory hallucinations before and was never warned that I might suffer from them--it turns out auditory hallucinations are common in *healthy* people after bereavement), and I'm incredibly sorry about it... I'm begging for your forgiveness, and whether or not you grant it I'll do my best to make amends. I'm trying to do this the best I can... I promise I won't kill myself or do any other harm to you, and will do everything I can to make it up to you.

PS: Listing Christianity as a "Characterological Problem" is ironic, OK? I'd been given shit about it already... I refer to K because I'd told Amari that I felt like going to see Fran Markover was like K in The Trial, repeatedly going to the "court" on his own impetus and asking for trouble. I was right...

47 citations found

Zentralbl Bakteriol [Orig A] 1979 Oct;**245(1-2):**144-149

Autoimmune reactions associated with Mycoplasma

pneumoniae infection.

Biberfeld G

Patients with Mycoplasma pneumoniae infection often develop various autoantibodies including cold agglutinins, cold antibodies reacting with lymphocytes, antibodies against various tissue antigens, for instance brain and lung and smooth muscle antibodies. Various mechanisms that may be responsible for the induction of these autoimmune responses and the possible pathogenicity of these autoantibodies are discussed.

PMID: 44608, UI: 80194131

Muscle Nerve 1995 Apr;**18(4):**409-413

Anti-Gal-C antibody in autoimmune neuropathies subsequent to mycoplasma infection.

Kusunoki S, Chiba A, Hitoshi S, Takizawa H, Kanazawa I

Four of 82 patients with Guillain-Barre syndrome (GBS) and 1 of 12 with multifocal motor neuropathy (MMN), who previously had had Mycoplasma pneumoniae infections, had serum antibody to galactocerebroside (Gal-C). Two patients with GBS without mycoplasma infection also had anti-Gal-C antibody, whereas none of the normal or the disease controls had it. As Gal-C is a major glycolipid antigen in myelin, anti-Gal-C antibody may function in the pathogenesis of autoimmune demyelinative neuropathies. Mycoplasma pneumoniae appears to be an important preceding infectious agent in autoimmune neuropathies with anti-Gal-C antibody.

PMID: 7715626, UI: 95231542

Clin Infect Dis 1993 Aug;**17 Suppl 1:**S52-S57

CNS manifestations associated with Mycoplasma pneumoniae infections: summary of cases at the University of Helsinki and review.

Koskiniemi M

CNS manifestations appear in one of 1,000 patients with Mycoplasma pneumoniae-associated infections. Encephalitis is the most frequent manifestation, but cases of meningitis, myelitis, and polyradiculitis, as well as many other symptoms (e.g., coma, ataxia, psychosis, and stroke), have been reported. The onset of these manifestations is usually acute, with lowered consciousness, convulsions, pareses, and other neurological signs. Severe, even fatal, cases are known. The pathophysiology of CNS manifestations is unknown. To our knowledge, M. pneumoniae has never been isolated from brain tissue, but instead it has been recovered from CSF specimens in at least seven cases. Besides direct invasion of M. pneumoniae into the brain, neurotoxic or autoimmune reaction within the brain tissue is suspected. At neuropathological examination, edema, demyelination, and microthrombi have been described. Improved diagnostic methods may reveal the pathophysiology of CNS manifestations associated with M. pneumoniae infection.

Publication Types:

- Review
- Review, tutorial

PMID: 8399938, UI: 94002853

South Med J 1991 Oct;**84(10):**1255-1258

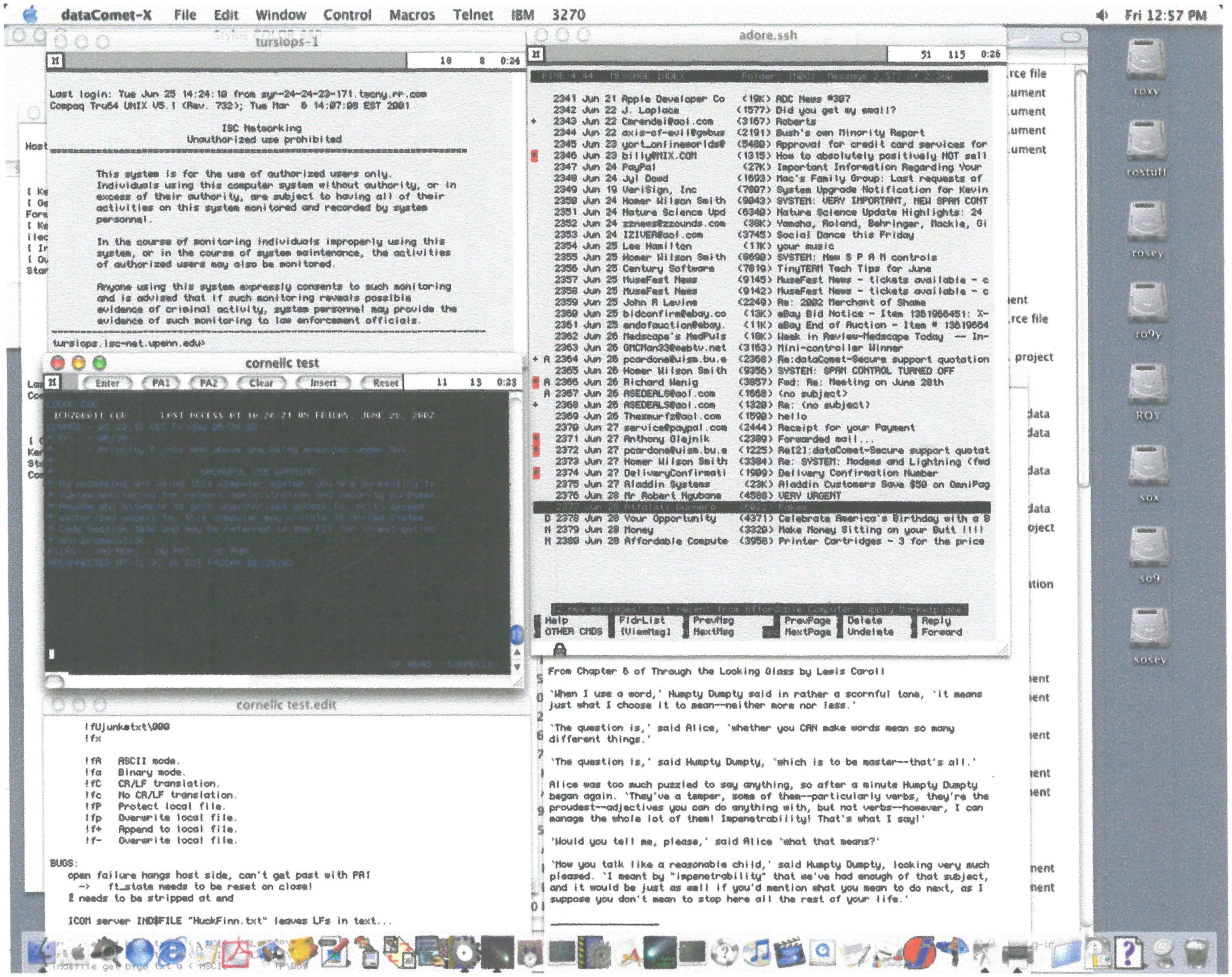
Central and peripheral nervous system demyelination after infection with Mycoplasma pneumonia: evidence of an autoimmune process.

Kollet MH, West S, Davis DR, Winn RE

We have reported a unique case of multiple central and peripheral nervous system

abnormalities after a serologically documented infection due to Mycoplasma pneumoniae. The evidence suggests that this organism is capable of causing demyelination, probably through an autoimmune process. This case may help to provide further insight into the pathogenetic mechanisms involved in other demyelinating diseases in which the triggering exogenous agent is unknown. Certainly this case demonstrated that both central and peripheral nervous system demyelination can occur and that patients with M pneumoniae infections should be observed closely for possible development of neurologic symptoms.

PMID: 1925728, UI: 92022741



dataComet-X File Edit Window Control Macros Telnet IBM 3270
Fri 12:57 PM
tursiops-1
adore.ssh
Last login: Tue Jun 25 14:24:10 from syr-24-24-23-171.twcny.rr.com
Compaq Tru64 UNIX V5.1 (Rev. 732); Tue Mar 6 14:07:08 EST 2001
ISC Networking
Unauthorized use prohibited
This system is for the use of authorized users only. Individuals using this computer system without authority, or in excess of their authority, are subject to having all of their activities on this system monitored and recorded by system personnel.
In the course of monitoring individuals improperly using this system, or in the course of system maintenance, the activities of authorized users may also be monitored.
Anyone using this system expressly consents to such monitoring and is advised that if such monitoring reveals possible evidence of criminal activity, system personnel may provide the evidence of such monitoring to law enforcement officials.
tursiops.isc-net.upenn.edu>
cornellc test
Enter PA1 PA2 Clear Insert Reset
cornellc test.edit
!fUjunk.txt\000
!fx
!fA ASCII mode.
!fa Binary mode.
!fC CR/LF translation.
!fc No CR/LF translation.
!fP Protect local file.
!fp Overwrite local file.
!f+ Append to local file.
!f- Overwrite local file.
BUGS:
open failure hangs host side, can't get past with PA1
-> ft_state needs to be reset on close!
2 needs to be stripped at end
ICON server IND$FILE "HuckFinn.txt" leaves LFs in text...
Help OTHER CMDS FldrList [ViewMsg] PrevMsg NextMsg PrevPage NextPage Delete Undelete Reply Forward
From Chapter 6 of Through the Looking Glass by Lewis Caroll
'When I use a word,' Humpty Dumpty said in rather a scornful tone, 'it means just what I choose it to mean--neither more nor less.'
'The question is,' said Alice, 'whether you CAN make words mean so many different things.'
'The question is,' said Humpty Dumpty, 'which is to be master--that's all.'
Alice was too much puzzled to say anything, so after a minute Humpty Dumpty began again. 'They've a temper, some of them--particularly verbs, they're the proudest--adjectives you can do anything with, but not verbs--however, I can manage the whole lot of them! Impenetrability! That's what I say!'
'Would you tell me, please,' said Alice 'what that means?'
'Now you talk like a reasonable child,' said Humpty Dumpty, looking very much pleased. 'I meant by "impenetrability" that we've had enough of that subject, and it would be just as well if you'd mention what you mean to do next, as I suppose you don't mean to stop here all the rest of your life.'
roxy
rostuff
rosey
ROY
sox

1: Am J Psychiatry 1997 Feb;154(2):289

Compulsive computer use.

Belsare TJ, Gaffney GR, Black DW.

Publication Types:

- Letter

PMID: 9016287 [PubMed - indexed for MEDLINE]

NOVARTIS

T2001-88
89004903

Trileptal®
(oxcarbazepine)

Tablets

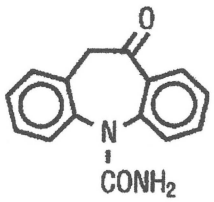
Oral Suspension

Rx only

Prescribing Information

DESCRIPTION

Trileptal® (oxcarbazepine) is an antiepileptic drug available as 150 mg, 300 mg and 600 mg film-coated tablets for oral administration. Trileptal is also available as a 300 mg/5mL (60 mg/mL) oral suspension. Oxcarbazepine is 10,11-Dihydro-10-oxo-5*H*-dibenz[b,*f*]azepine-5-carboxamide, and its structural formula is



Oxcarbazepine is a white to faintly orange crystalline powder. It is slightly soluble in chloroform, dichloromethane, acetone, and methanol and practically insoluble in ethanol, ether and water. Its molecular weight is 252.27.

Trileptal film-coated tablets contain the following inactive ingredients: colloidal silicon dioxide, crospovidone, hydroxypropyl methylcellulose, magnesium stearate, microcrystalline cellulose, polyethylene glycol, talc and titanium dioxide, yellow iron oxide.

Trileptal oral suspension contains the following inactive ingredients: ascorbic acid; dispersible cellulose; ethanol; macrogol stearate; methyl parahydroxybenzoate; propylene glycol; propyl parahydroxybenzoate; purified water; sodium saccharin; sorbic acid; sorbitol; yellow-plum-lemon aroma.

CLINICAL PHARMACOLOGY

Mechanism of Action

The pharmacological activity of Trileptal® (oxcarbazepine) is primarily exerted through the 10-monohydroxy metabolite (MHD) of oxcarbazepine (see Metabolism and Excretion

subsection). The precise mechanism by which oxcarbazepine and MHD exert their antiseizure effect is unknown; however, in vitro electrophysiological studies indicate that they produce blockade of voltage-sensitive sodium channels, resulting in stabilization of hyperexcited neural membranes, inhibition of repetitive neuronal firing, and diminution of propagation of synaptic impulses. These actions are thought to be important in the prevention of seizure spread in the intact brain. In addition, increased potassium conductance and modulation of high-voltage activated calcium channels may contribute to the anticonvulsant effects of the drug. No significant interactions of oxcarbazepine or MHD with brain neurotransmitter or modulator receptor sites have been demonstrated.

Pharmacodynamics

Oxcarbazepine and its active metabolite (MHD) exhibit anticonvulsant properties in animal seizure models. They protected rodents against electrically induced tonic extension seizures and, to a lesser degree, chemically induced clonic seizures, and abolished or reduced the frequency of chronically recurring focal seizures in Rhesus monkeys with aluminum implants. No development of tolerance (i.e., attenuation of anticonvulsive activity) was observed in the maximal electroshock test when mice and rats were treated daily for 5 days and 4 weeks, respectively, with oxcarbazepine or MHD.

Pharmacokinetics

Following oral administration of Trileptal tablets, oxcarbazepine is completely absorbed and extensively metabolized to its pharmacologically active 10-monohydroxy metabolite (MHD). The half-life of the parent is about 2 hours, while the half-life of MHD is about 9 hours, so that MHD is responsible for most antiepileptic activity.

Based on MHD concentrations, Trileptal tablets and suspension were shown to have similar bioavailability.

After single dose administration of Trileptal tablets to healthy male volunteers under fasted conditions, the median t_{max} was 4.5 (range 3 to 13) hours. After single dose administration of Trileptal oral suspension to healthy male volunteers under fasted conditions, the median t_{max} was 6 hours.

In a mass balance study in people, only 2% of total radioactivity in plasma was due to unchanged oxcarbazepine, with approximately 70% present as MHD, and the remainder attributable to minor metabolites.

Effect of Food: Food has no effect on the rate and extent of absorption of oxcarbazepine from Trileptal tablets. Although not directly studied, the oral bioavailability of the Trileptal suspension is unlikely to be affected under fed conditions. Therefore, Trileptal tablets and suspension can be taken with or without food.

Steady-state plasma concentrations of MHD are reached within 2-3 days in patients when Trileptal is given twice a day. At steady-state the pharmacokinetics of MHD are linear and show dose proportionality over the dose range of 300 to 2400 mg/day.

In the clinical trial, in which the intention was to reach these target doses, the median daily dose was 31 mg/kg with a range of 6-51 mg/kg.

The pharmacokinetics of Trileptal are similar in older children (age >8 yrs) and adults. However, younger children (age <8 yrs) have an increased clearance (by about 30%-40%) compared with older children and adults. In the controlled trial, pediatric patients 8 years old and below received the highest maintenance doses.

Children below 2 years of age have not been studied in controlled clinical trials.

Patients with Hepatic Impairment

In general, dose adjustments are not required in patients with mild-to-moderate hepatic impairment (see CLINICAL PHARMACOLOGY, Pharmacokinetics, Special Populations subsection).

Patients with Renal Impairment

In patients with impaired renal function (creatine clearance <30 mL/min) Trileptal therapy should be initiated at one-half the usual starting dose (300 mg/day) and increased slowly to achieve the desired clinical response (see CLINICAL PHARMACOLOGY, Pharmacokinetics, Special Populations subsection).

HOW SUPPLIED

Tablets

150 mg Film-Coated Tablets: yellow, ovaloid, slightly biconvex, scored on both sides. Imprinted with T/D on one side and C/G on the other side.

Bottle of 100 ..... NDC 0078-0336-05
Bottle of 1000 ..... NDC 0078-0336-09
Unit Dose (blister pack)
Box of 100 (strips of 10) ..... NDC 0078-0336-06

300 mg Film-Coated Tablets: yellow, ovaloid, slightly biconvex, scored on both sides. Imprinted with TE/TE on one side and CG/CG on the other side.

Bottle of 100 ..... NDC 0078-0337-05
Bottle of 1000 ..... NDC 0078-0337-09
Unit Dose (blister pack)
Box of 100 (strips of 10) ..... NDC 0078-0337-06

600 mg Film-Coated Tablets: yellow, ovaloid, slightly biconvex, scored on both sides. Imprinted with TF/TF on one side and CG/CG on the other side.

Bottle of 100 ..... NDC 0078-0338-05
Bottle of 1000 ..... NDC 0078-0338-09
Unit Dose (blister pack)
Box of 100 (strips of 10) ..... NDC 0078-0338-06

Store at 25°C (77°F); excursions permitted to 15°C-30°C (59°F-86°F) [see USP Controlled Room Temperature]. Dispense in tight container (USP).

Suspension

300 mg/5 mL (60 mg/mL) Oral Suspension: off-white to slightly brown or slightly red suspension. Available in amber glass bottles containing 250 mL of oral suspension. Supplied with a 10 mL dosing syringe and press-in bottle adapter.

Bottle containing 250 mL of oral suspension ..... NDC 0078-0357-52

Store Trileptal oral suspension in the original container. Shake well before using.

Use within 7 weeks of first opening the bottle.

Store at 25°C (77°F); excursions permitted to 15°C-30°C (59°F-86°F) [see USP Controlled Room Temperature].

T2001-88

REV: DECEMBER 2001 Printed in U.S.A. 89004903

NOVARTIS

Tablets Manufactured by:
Novartis Pharma Stein AG
Schaffhauserstrasse 48
CH-4332 Stein, Switzerland

Oral Suspension Manufactured by:
Novartis Pharma S.A.
F-68330 Huningue, France

Distributed by:
Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936

Ronald Leifer MD DeWitt Pl 272-7334 / 732-9356

Peter Breggin MD

Lawyers — 2

Jeff Coleman 277-1916

Scott Miller 273-5475 200 E Buffalo

Jim Baker 275-9916 148 The Commons

+ Jim Hickey N Tioga 273-2039

Richard Ruswick

Mike — MTW Mom's money locked up---

510 582 7093

Wm. Proctor 387-6826

4/29 Tuesday

Lithium 300 BID 2x

Valproic Acid 250 BID 2x

Zyprexa (zydis – olanzapine wafer)

5/4 11:50 Naomi asks me to come in the nursing station... Says there's been a "crazy report" that I have a knife, so I turn out my pockets etc., explain how Steve Seagal uses a credit card to kill 3 people in one stroke in "Glimmer Man", but no knife on me!

5/5 9:15 Dr. Pavnelli calls me in for brief meeting re: assault by Bill Sherman. Once again I note that I reject their "cure" & requested that my ward restriction be lifted.

PRO:

Release Hearing, Judge Hayden:

p. 15:
Cocciola: "Would he pose a risk of danger to himself or others?"
Povinelli: "I believe if he got back to the marijuana again, he might certainly pose a risk."

And if not?

p. 57
Q ...what would you identify ... as risk factors that would make him dangerous to be in the community?
Povinelli: What would make Mr. Saunders dangerous would be a repeat performance of not taking medication, becoming manic, and adding marijuana into it. And drugs.

P. 75
Belsare: I was called by Cayuga County Medical Center by a nurse April 4th of this year, and she said that he had come into the hospital and that his presentation was one of him saying he had delusions.

Having myself taken in to the hospital when I realize I am delusional is a sign of cooperation rather than dangerousness.

Judge Rowley

Dr. Roberts

Insight

p. 29: "He says he does not have a mental illness":

By the legal definition, not the medical one. When the issue is raised, I ask which sense is meant (a medical illness presumably requires care and treatment, the legal definition posited in the MH law adds "rehabilitation" without any definition, either by example or elaboration). I don't think my current confinement promotes "rehabilitation." It appears the term is used loosely.

Dr. Roberts goes on to generalize this position as a rejection of all psychiatric diagnoses, which is not my position at all.

Etiology/Precipitants

p. 23: "And then he became paranoid by completely evading any conversation about himself when asked questions about his past history to try to enlighten him."

Huh? This was not the case.

p.23 "And we could never get him to discuss any precipitants until finally the social worker asked him why did you burn down the trailer, and he said I was angry."

Totally false, I've *never* made any statement to the effect that I was "angry" precisely because it's simply not the case: I was delusional and *scared spitless* over the prospect that "Hannibal Lecter" had somehow threatened to release biological warfare agents, e.g., anthrax. (This claim probably comes from Dr. Kennedy's baseless assertion that I was angry at the time of the arson. Dr. Povinelli describes my response a little more accurately in Hayden p. 14, except that I *don't* equate myself with Lecter!.)

P. 31: Convulsions in ambulance on trip to Elmira.

Dangerousness

p. 30:
Q: "Do you feel if he were discharged right now he would pose a risk of harm to himself or others?"
A: "Yes."
Q: "What do you base that on?"
A: "Past history of violence, arson, and assaultive behavior during prior episodes of decompensation."

NOTE I believe a higher standard of probability than mere "risk" applies (?)

p. 44: "His housemates took him to the hospital ... after he was trying to hurt himself."

False, I was not trying to hurt myself. I never did anything over the duration of the psychosis with the *intention of harming myself (claims from the CMC about "scalding himself" and "trying to hurt himself by* banging his hands" are misperceptions).

Medication:

p. 18:
A I prescribed Zyprexa or Zydis.
...
Q *And what prescription dosage or strength have you recommended?*
A I believe I started him at 15.
Q That's a low dosage? What kind of dosage is that?
A Well, studies have indicated that a patient receives maximum benefit and more rapid improvement if one starts at 15 or 20 milligrams. So I started where the studies are indicating.
Q Is that per day?
A Yes

From the monograph on olanzapine: "Olanzapine should be administered... beginning with 5 to 10 mg initially, with a target dose of 10 mg/day within several days." ... "Antipsychotic efficacy was demonstrated in a dose range of 10 to 15 mg/day in the clinical trials. However doses above 10 mg/day were not demonstrated to be more efficacious that the 10 mg/day dose. ... The safety of doses above 20 mg/day has not been evaluated in clinical trials."

p. 22: "... on a second occasion when I tried to – no, maybe a third. On another occasion when I tried to reinforce this idea by repeating a somewhat familiar statement in front of the team he became very angry and irritable and agitated during that interview."

It seems she can't really recall; presumably on 4/24 during the second real meeting with her (i.e., a meeting longer than 3 minutes), she made some effort to urge me to take Zyprexa, however once started along the "why did you commit the arson" trail I upon which I was launched early in the interview, I do indeed tend to become *upset!*

P. 24: "when I admitted Mr. Saunders... [medication/marijuana discussion] ... he refused to listen to that."

p. 47:
Q "Dr., how many times have you approached Mr. Saunders about taking medication?"
A: "At least four if not more." ... "Then we had a treatment plan meeting. That was another setting in which he was *given an opportunity to hear the medication recommendation.*"

Dr. Roberts may have engaged in a discussion of medications with me when I was still psychotic on 4/4 (as she

states herself, p. 16 passim!), but I certainly could not recall this conversation later. She did not discuss medications in other contexts. The Treatment Plan meeting was a repetition of the nightmare on 3/13, where a document listing various extreme allegations was presented, and I was supposed to sign the document: "He has a history of extreme violence against women," can't work successfully in a supervised setting, a recital of claims purportedly made by Susan Hamann in Dr. Kennedy's report, etc. This was hardly a context for "education," or an effort at persuasive engagement!)

Treatment Plan

p. 30:
Q: "And what would this medication do for him?"
A: "It would normalize his moods so he is neither manic, depressed, or irritable, lowering the threshold for circumstances which cause him to become agitated and angry, and also likely to treat his psychotic symptoms, paranoia, his preoccupation with being persecuted, and his violence."

NOTE that Dr. Roberts stated to me sometime after the hearing ended, around 5/20, that she thought I might be able to use Zyprexa only on an as-needed basis, and later that "whatever happens, we'll try to make sure that you don't wind up here. You don't belong in a place like this – you have too many strengths." This was after she asked to speak with me, and I started by complaining to her about the unfounded allegations of serial rape which appeared in her TOO application. I was upset, but we had a fairly reasonable (public) conversation on the issues, including discussing Susan's assault complaint, with me briefly noting that she had a prior history of abuse and suffered from PTSD after Dr. Roberts' asked whether she had suffered abuse in the past.

P. 45: "Well, this is his choice. These are the consequences which he is well aware of as being possible when he refuses to take medication and continues using marijuana. So I see this as his choice."

As Mr. Wenig noted later, this appears to advocate a punitive stance.

Judge Hayden

p. 15 Povinelli: "He has not been compliant with his conditions as a CPL patient for five years now."

This is false... I was compliant except for a couple of brief episodes of marijuana use for 3 whole years. Dr. Brink recommended Depakote once, I declined, she didn't encourage me to try medication in any of the 2 meetings I subsequently had with her.

PRO:

p. 15:
Cocciola: "Would he pose a risk of danger to himself or others?"
Povinelli: "I believe if he got back to the marijuana again, he might certainly pose a risk."

Recommitment Hearing Judge Rowley

Dr. Povinelli

p. 51-52:
Q: When you saw him in 1997 can you describe his behavior?
A: He was aware that he was acting psychotic himself. At that time he was showing signs of mania....
A: ... I felt that he showed the signs and symptoms of a bipolar disorder.
Q: What symptoms did you observe at that time?
A Pressured speech. He wasn't thinking clearly. He believed there was a conspiracy with regard to the police and

False, I no longer believed in this at that time. I was describing my beliefs at the time of the arson. Note the police conspiracy was a conspiracy of "good guys" (!).

P. 53: A: The diagnosis was bipolar disorder with psychotic features mood congruent.

False, it was "affective disorder with psychotic features": Depression.

P. 53
A: ... In 1997 he felt he was suffering from a drug disorder.

P. 55:
Q: Does he accept the diagnosis of bipolar? ... Did he back in 1997?
A No. In 1997 he felt that his illness was due to a drug reaction.

False, in 1997 at the time of my interview by Povinelli I believed I was suffering from a bizarre combination of neurological disorders (CIDP + TLE). Only 3 years later did I discover that Trazodone can cause peripheral numbness & that its byproduct mCPP is anxiogenic (and probably hallucinogenic).

Dangerousness

p. 57
Q ...*what would you identify ... as risk factors that would make him dangerous to be in the community*?

A What would make Mr. Saunders dangerous would be a repeat performance of not taking medication, becoming manic, and adding marijuana into it. And drugs.

Treatment Plan

p. 59 I recommend he be placed on medications as prescribed by Dr. Roberts, mood stabilizer, possibly an antipsychotic.

Belsare

Here she refers to the humbug about "may" means "must":

p. 64 A: I did mention to him that medications were ordered. On the Order of Conditions it was a legal requirement.
Q And what did he say?
A Well, he didn't believe that they were.

P. 68

re: Urine screen refusals, I had stated that I did not want to pay $50 for urine screens.

p. 69
Q Had you advised Mr. Saunders at any time that you thought he was in violation of his conditions?
A Yes

Only the first time I refused the Trileptal. Otherwise both Dr. Belsare and Janet Stevens claimed they were "trying to help me through my last year."

P.76
Q Do you feel if he were released he would pose a physical danger to himself or others?

A Yes, probably, yeah. ("probably"?)

Saunders

p. 230 MUST COPY!

Q You were upset about the fact ...
A These were never corrected. I discussed this at length with my therapist, and none of the problems were fixed.
Q And so that was distressing to you?
A Yes
Q And so you were unable to work as a result, really concentrate on your work?
A Not unable to work. I was unable to do –
Q Heavy lifting, right?
A – significant computer programming.

Belsare

MUST COPY: p. 63, amazing Belsare "borderline narcissistic features" comment: "injured ego ... compensates for by valuing their own performance as being extraordinary or greater, or themselves as being more important than they are in society."

P. 72
Q So last month it was schizophrenia. Now you are saying it's bipolar and possible schizo-affective disorder?
A There has been confusion about what his diagnosis is.

P. 73-74

Schizophrenia is manifested by: asserting I had 4 rather than 2 knives! (She misses the point I was trying to make completely. Repetition of this falsehood in the "Review" and elsewhere is very upsetting to me because it involves evidence suppression and perjury on the part of the State Troopers investigating the arson. I don't believe this error bearing on whether I should be under an order of conditions -- it bears on the question of whether these officers belong in uniform.)

Sanity is: "But, okay, ex-wife/girlfriend." !!!!!!!!