5. EVIDENCE OF BIAS at TCMH

- Gerard Lippert MD
- Pages 22-27 from 2012-07-24 Filings
  Confidential-2
- TCMH PROGRESS NOTES

Highlighted text denotes items of interest;
Underlined text indicates errors;
Green boxes are used for hyperlinks.

Bonze Blayk 2019.03.12 17:26:32 -04'00'

Tompkins County Mental Health
PROGRESS NOTES
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Client Name/# BONZEANNE R BLAYK (10389) Note seq: 21

Client Name/# :BONZEANNE R BLAYK (10389) Note seq: 21
Service date/time:09/14/11 at 4:00 PM Duration: 1:00
Service provided :016 - PSYCH ASSESSMENT-45 Program :FA/ 3
Provided by :GL1 GERARD LIPPERT, MD
Note signed by :GL1 on 09/30/11 at 2:34 PM Signed :Y

Time: 60 min.

Psychiatric Assessment - CPL 330.20 Examination

Re: Bonze Blayk (BB) (previously Kevin Saunders) previously "Kevin Eric Saunders a/k/a bonze blayk"

Purpose of Exam : BB is requesting a discharge from his order for out-patient treatment under CPL 330.20. He was arrested on 2/6/97 and charged with the crimes of burglary 2nd degree, arson 3rd degree, two counts of criminal mischief 2nd degree and criminal contempt 1st degree. He was adjudicated as non-responsible by reason of mental disease on Innocent of malice 6/28/97. He has been under the condition to maintain out-patient treatment since December 2008.

Instant Offense: The criminal charges referenced above were related to an incident which occurred on or about 2/6/97. On that occasion BB drove to home of his girlfriend (SH) finding her not present. It is reported that there were two knives found in the car but it is not clear if he took these into the trailer. He broke in, spread lighter fluid about the residence, lit the fluid and left. He was apprehended soon after as he was driving away from the scene. 4 knives

"Haven't you ever heard of having 'too much evidence?'" - Lady trooper to the arresting officer the morning of the offense.

Psychiatric Hx: Review of the extensive records available to this writer revealed that BB began to identify himself as female at least as early as middle childhood and that he has maintained this identification consistently to the present. "androgynous" He first sought mental health treatment because of depression in 1988 and received counseling briefly at Family and Children's Services. In subsequent years he was also referred to EAP 2/92 Stotz through his employer, Cornell University, because of inter-personal Salary Tiff - resolved conflicts in the workplace. In the early 1990s he and his wife of the time 1992 developed marital problems which evolved to an incident of domestic one violence on BB's part. No charges were laid but he did see a psychiatrist CLOSETED for a time and the couple received marital counseling. The psychiatrist RAPE diagnosed cyclothymia and identified cannabis misuse as a problem. VICTIM Treatment apparently ended with the break-up of the marriage. BB's next episode of treatment took place at FCS beginning in May of 1996. It was during this treatment that he was prescribed prozac and, later, trazodone. Cannabis dependence was also identified but, for a period of some months, not to me BB was abstinent from this substance on the recommendation of his

For reasons unclear to me Dr. Lippert fails to address a potential issue relating to mania: in 1990, when I devoted 80-100 hours/week over the course of three months to work developing COMET, fueled by caffeine, tobacco, and cannabis, was I suffering from a 'manic phase'? - "No, it was *hard work*." - AnneRose

therapist.

BB has consistently reported that he was psychotic at the time of the offense and he has also insisted that this psychosis was brief in duration. He has presented an explanation of the motivation for his behavior which was based upon a complex delusional system related to the novel, The Silence of the Lambs. Although he had a hx of using cannabis heavily for many years he stated that he was not using at the time of the offense nor had been for some months previously. He has consistently insisted that the psychotic sx were related to a drug-drug interaction between fluoxetine and trazodone (started in early January 1997 as a sleep aid) which led to an elevated level of mCPP. This compound has been reported to be psychotogenic, particularly in persons genetically predisposed to low levels of CYP450 2D6; BB has tested as an intermediate metabolizer at 2D6. In any event the psychotic sx were transient and he was not seen as requiring on-going anti-psychotic medication in several follow-up evaluations which occurred in the months after the event.

Inherited P450-2D6*4 heterozygous allele, where one of two alleles are entirely inactive - $300 out-of-pocket expense for testing 7/16/2010.

Of note, these offenses occurred at the culmination of a period of escalating aggressive and otherwise unstable behavior on the part of BB subsequent to his starting prozac in August 1996. Over this period he experienced increased angry outbursts which resulted in uncharacteristic altercations with SH and her deciding to move out of his home. He stated that he had stopped using cannabis around the time the prozac was started and did not use again for several months. In late December 1996 he was charged with a DUI; his blood alcohol level by breathalyzer was reported to be 0.15 % at the time. Soon after police were called to his home on the complaint of SH that he had sexually assaulted her. Unregistered firearms were also found at the scene ~~but~~ charges were ~~not~~ laid regarding these incidents. Also of note was that BB experienced a variety of vague neurologic sx during January 1997 and became somatically preoccupied. He presented at the ER on one occasion and also pursued an evaluation with J Stackman thinking he might have a chronic neurologic disorder.

one
12/22/96
spiked
drink
false
heirlooms
12/29/96
precisely summarized

A botched discussion of "A Three-Way Train Wreck on P450IID6," which first I submitted in the year 2000, along with this open letter.

Following his arrest BB was seen while incarcerated at TC jail and maintained on prozac although he refused anti-psychotic medication. There was no evidence he was psychotic at the time. After being released on bail he was followed by his PCP who continued to prescribe prozac until BB stopped this medication around July 1997. By this time he had relapsed on cannabis and was again using heavily. His next contact with this MHC occurred in August 1997 at which time he presented for a court-ordered evaluation related to a custody dispute with his ex-wife regarding their daughter. No medication was prescribed at that time. In March 1998 he was mandated for a forensic examination to RRFU. Because he refused to stop using cannabis to eliminate the confounding effects of this drug he was admitted to the RRFU for approximately 2 months during which time he was extensively evaluated. These evaluations were conducted by R. P. Singh, M. D. and John Kennedy, M. D. and are available on-line at a web-site maintained by BB who provided the URL to this writer. Both evaluators concluded that BB did not suffer from a dangerous mental disorder and

self-report
CPL 730 Exam

My own testimony does not qualify as 'evidence' - why is that? ==> "Distrust elevated to the status of a 'methodology'."

presented no risk to himself or others. He was discharged to follow-up with this MHC but medication was not prescribed. He reported that he was maintaining abstinence from cannabis per court order.

Over the course of the next few years BB continued to see L Riley of this MHC for supportive counseling and over-sight. He was apparently stable though this period and spoke in therapy of his life-long identification as female as well as issues related to inter-personal conflict. He was not taking psychotropic medication and was seen annually by A Brink, M. D., clinic psychiatrist, for evaluation. Her impression was that he was not psychotic but did exhibit traits of borderline PD. He insisted he was not using drugs or alcohol but did have several urine screens positive for cannabinoids. This led to the possibility of sanction or re-assessment of his status but no action was taken other than that BB was again informed that his use of cannabis was in violation of his court order. As his counseling with L Riley continued he began to refuse to provide urine samples for testing and it appears that this was again not sanctioned.

In April 2002 BB was admitted to the BHU at CMC because of "psychotic decompensation". (Original records from CMC were not available and this information has been extracted from a discharge summary of his lengthy hospitalization at EPC from September 2004 to November 2007.) BB presented with agitation, formal thought disorder and grandiose delusions. His psychotic sx apparently cleared without treatment and he was discharged on no anti-psychotic medication. His follow-up was transferred at that time to the out-patient clinic at Elmira Psychiatric Center. Over the course of the next year of out-patient follow-up he continued to refuse to accept psychotropic medication and to submit to urine toxicology screening. In April of 2003 he was taken to the ER of CMC (again as documented in the EPC discharge summary) with a history of elevated mood, agitated, bizarre behavior including running about outside for several hours while naked and grandiose delusions. On this occasion he admitted to daily cannabis use. He was transferred to EPC where he was initially aggressive requiring both chemical and physical restraint. Following stabilization he was transferred to the RRFU where he was maintained on in-patient status until Sept 2004. During this hospitalization he was treated with Risperdal Consta 25 mg IM and this was continued following his transfer back to EPC in Sept 2004. ..after being on oral Risperdal for about a year, when Igor Kashtan MD suggested that the clinicians in the civil hospital would probably prefer to see me on Consta, I volunteered to go on Consta. I was never placed under a TOO until 1/5/16 at CMC's BSU.
Over the course of the next 3 years BB remained a patient at EPC receiving Consta injections. He gradually moved to out-patient status and was living in a community residence associated with EPC. Through this period he exhibited no psychotic sx and was found to have negative urine toxicology screens. In late 2007 his case was re-evaluated by the Forensic Bureau and it was determined that he could be discharged back to this community with the plan to be referred to this MHC for continuing medication management and monitoring of his stability. He reentered treatment at this MHC in December 2007 at which time he was noted to be euthymic with no psychosis although he did report some restlessness suggestive of akathisia. Over the course of the next several months Consta was continued but the was

PCP I

PCP II

"he"

eventually switched to oral risperidone because of persistent akathisia. However, he began to develop involuntary facial movements which were ~~felt to be~~ early tardive dyskinesia and he was switched to seroquel. This agent was gradually tapered and was stopped altogether in March 2010. In addition, urine toxicology screens were performed every 3 months, on a random basis on some occasions, with no positive screens. BB has been maintaining appropriate housing and has become involved in pursuing a career in music. He has also been moving towards a full transition to a female identity and is receiving therapy from J Zager, PhD to facilitate this. His physical health is stable other than for hypertension controlled by spironolactone which also happens to be anti-androgenic.

BB has had no direct contact with SH since approximately 1998. Although he is acquainted with her current romantic partner he has not pursued seeing her in person. He described SH in very positive terms as "the most brilliant, beautiful woman (he) has ever known" ~~but~~ stated he will always and respect her desire to not have contact with him. He stated he has made efforts to pay compensation for the property destroyed in the fire. He stated he has not had any malicious feelings towards her or towards any other person in the 13+ years since the incident. He also stated that he has not used cannabis since before his hospitalization in 2003 and has every intention of maintaining his abstinence.

"Malicious" - revealing a presumption of guilt in my arson offense, despite a finding of innocence by the court (formalized in PEN 40.15).

"His" status (eyeroll)

Mental Status: BB presented on time for this evaluation and was found waiting quietly in the waiting room. He was dressed in a black dress and wore female stockings and shoes. His hair was long and well-cared for. He did not wear obvious make-up. His gestures were effeminate and his voice somewhat high-pitched. There were no abnormalities of behavior. He was cooperative and truthful in this interview as far as could be determined by the examiner and clearly eager to make a positive impression. He emphasized his theory of the cause for his psychotic sx at the time of the offense was the interaction of trazodone with prozac. He also tended to downplay the seriousness of his episodes of psychosis in 2003 and 2004. His speech was somewhat pressured and he often insisted on relating a very detailed account of events from his perspective. He exhibited a broad range of affect which verged on disinhibited at times. His mood was euthymic. His thought processes were coherent but somewhat circumstantial and discursive. He did not report or endorse any suicidal ideation or violent intent. He did not report any psychotic sx and did not endorse any Schneiderian first rank sx. He was fully alert and clearly of above average intelligence with a subtle attitude of dismissal of others who did not equal his intellect or knowledge. On the basis of this interview and review of recent reports available in his chart it appears that his insight and judgment are intact.

My "attitude of dismissal" is reserved for those who do not try to get their facts straight and mind-gamers, not for those of lesser intellect.

Formulation: It is apparent that BB has suffered from at least 3 episodes of psychosis, including that which occurred at the time of his criminal behavior. There are several possible etiologies for these episodes, none of which excludes the others. BB attributed the psychosis at the time of his criminal behavior to the drug-drug interaction of prozac and

Re: "several possible etiologies": See the DSM-IV on "Differential Diagnosis of Psychotic Disorders" - vs. three exposures: mCPP, PCP I, and PCPII.

trazodone. This precipitant cannot be invoked for the other episodes. Another relevant etiology is cannabis use and there is evidence that he was using this drug heavily prior to his hospitalizations for psychosis in 2002 and 2003. However, he has insisted that he was not using cannabis in the several months leading up to his criminal acts. Another possible explanation for his psychosis is a primary psychiatric disorder, either a psychotic disorder per se or a major mood disorder. The latter category seems more likely. There was a diagnosis of cyclothymia in the early 1990s. As well, his presentation resulting in the 2003 admission was one of psychotic mania and his diagnosis while at EPC was bipolar I disorder. PCP II Another piece of evidence, albeit circumstantial that he has bipolar disorder, was his reaction to prozac in late 1996 into 1997. He became more irritable with more aggressive, belligerent behavior and seemed to be more impulsive with poor judgment. This could represent a not unexpected adverse reaction to prozac in a person with bipolar disorder. He has not suffered a subsequent episode of mania, hypomania or major depression since 2003. Although he was being treated for much of this time with Risperdal Consta, an effective maintenance agent in bipolar disorder, medication doses were quickly tapered after his discharge from EPC and he has been off all medication for over a year. Exactly 2 years This in itself does not diminish the possibility of bipolar disorder as extended periods of relative mood stability without treatment are not unusual. Furthermore, subsyndromal sx may be present sporadically without coming to clinical attention. Another important factor in formulating an appropriate diagnosis is his long-standing personality traits which have been noted in most evaluations even when his Axis I diagnoses have varied widely. Borderline PD has been mentioned and it is well known that one of the complications of this condition is transient psychotic sx triggered by severe stress. My personality traits conform closely to "Geschwind Syndrome," which has been linked to Left Temporal Lobe Epilepsy: "Geschwind syndrome includes five primary changes; hypergraphia, hyperreligiosity, atypical sexuality, circumstantiality, and intensified mental life" (Wikipedia).

Psychiatric Diagnosis:

Axis I	1) Bipolar I disorder, currently stable.
	2) Cannabis dependence in full, sustained remission. "Medipot"
Axis II	1) Personality disorder, mixed, with borderline, histrionic and narcissistic traits.
Axis III	1) Hypertension.
Axis IV	1) Occupational problems.
	2) Problems related to interaction with the legal system.
Axis V	Current GAF: 65.

Recommendations: Although it is this evaluator's opinion that BB does likely have a diagnosis of bipolar disorder, this illness is currently in remission and has been for over 3 years without medication treatment that would be considered effective for maintenance of this disorder. In addition, he has been abstinent from cannabis for over 8 years and has consistently maintained his intention to continue this abstinence. Of some concern is his blas attitude to the severity of his past sx. In his favor are his apparent commitment to abstinence from cannabis and his regular involvement with a psychologist who would likely become aware of decompensation should this begin to occur. At this time it is this

writer's opinion that BB can be safely discharged from treatment and follow-up as required under CPL 330.20.

Signed electronically on 09/30/2011

Gerard (Jed) Lippert, MD/PSYCHIATRIST /Date

1/21/12

I reviewed this assessment and concur with the history. Since his symptoms in 2002 resolved without medication at discharge and since his 2003 admission was a long-running ~~schizo~~ substance-induced psychosis, I am simply diagnosing him with Psychotic Disorder NOS and Cannibis ~~inform~~ Dependence in remission on Axis I.

John Bezirganian. MD
John Bezirganian MD

Regarding 'evidence' - evidently my testimony is of no use whatsoever in the diagnosis of *my own* mental illness? Really?
"Always tell the truth... or at least don't lie." - I approve this message from Prof. Jordan B. Peterson PhD (Clinical Psychologist).
And what of my 8 1/2 years at Cornell? I am characterized as a bringer of "inter-personal conflicts" rather than "the developer of COMET," the COrnell Macintosh Emulator of Terminals, and its duly-licensed successors, dataComet and dataComet-Secure?
My psychosis in April 2003 lasted only five days before clearing, and it was obviously linked to unknowing consumption of PCP: see PCP II.
"Kevin Field PhD has offered the following diagnoses of serious mental illnesses for me, after over thirty sessions with him:
1) PTSD 2) Temporal Lobe Epilepsy - 'You don't fit any of the other diagnostic categories' - cf. Seized by Eve LaPlante"
(From an email to Richard Wenig Esq. MHLS 4/27/15)
Brian Babiak MD (psychiatrist) appears to agree with me that TLE is implicated in my illness, and recommended cannabis to treat PTSD 8/28/18.

- Bonze Anne Rose Blayk - March 5, 2019

Weblinks which appear highlighted in green boxes in this PDF fail under MacOS Preview, which the geniuses at Apple decided to turn into an incompetent PDF "editor" rather than sticking with it as a "preview" application; thus, I'm providing a list of the links here so viewers will be able to access these documents online. - AnneRose

1) previously Kevin Eric Saunders a/k/a bonze blayk
<http://securitydigest.org/tcp-ip/archive/1993/03>

2) 2/92 Stotz
<http://badtriprecords.biz/bonzeblayk/testify/therapyness/BARB/1992%20F&CS%20Ellen%20Stotz%20-%20Cornell%20EAP%20Referral.pdf>

3) Salary Tiff - resolved
<http://badtriprecords.biz/bonzeblayk/testify/cometmonger/2000-04-29-BARB-Salary-History.jpg>

4) Inherited P450-2D6*4 heterozygous allele, where one of two alleles are entirely inactive - $300 out-of-pocket expense for testing 7/16/2010.
<http://badtriprecords.biz/songs/dynasoar/gif/blayk/_bonze_blayk_CYP2D6.jpg>

5) A botched discussion of "A Three-Way Train Wreck on P450IID6," which first I submitted in the year 2000, along with this <open letter>.
<http://badtriprecords.biz/songs/dynasoar/gif/blayk/index.html> AND
<http://badtriprecords.biz/bonzeblayk/testify/2000-06-03%20KES-bb%20To%20Whom%20It%20May%20Concern.pdf>

6) CPL 730 Exam
<https://codes.findlaw.com/ny/criminal-procedure-law/cpl-sect-730-30.html> - A competency exam for a child custody case, rather than an evaluation for dangerousness (as one might think).

7) PCP II
<http://badtriprecords.biz/bonzeblayk/testify/2003-04-01-PCPATTACK.html>

8) 'Malicious' - revealing a presumption of guilt in my arson offense, despite a finding of innocence by the court (formalized in PEN 40.15).
<http://badtriprecords.biz/songs/dynasoar/gif/blayk/NY_Code_4015.html>

9) Re: 'several possible etiologies': See the DSM-IV on 'Differential Diagnosis of Psychotic Disorders' - vs. three exposures: mCPP, PCP I, and PCPII.
<https://www.facebook.com/photo.php?fbid=10150955876632954&set=a.429140027953&type=3&theater>