Jersey Forensic Consulting LLC

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DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY AND FORENSIC PSYCHIATRY

PSYCHIATRIC EVALUATION

Dates of Evaluation:	5/16/13
Date of Report:	5/17/13
Date of Birth:	1/24/76
Address:	252 Fountayne Lane, Lawrenceville, NJ
Phone:	732-698-8464
SS#:	not provided
Docket #:	FM-11-97-11 K
Judge:	Hon. Catherine Fitzpatrick, P.J.F.P.

Identifying Information:

Derek Syphrett is a 37-year-old African American ("No, that's going to be an issue for the standardized test" - he says he has a number of African and other ancestries although he says he does not identify with popular Black culture) male referred for psychiatric evaluation as part of an ongoing custody dispute. He is the father of two young children and the current matter has been ongoing for several years (exact dates are difficult to determine from the information provided). Mr. Syphrett presented for his evaluation 80 minutes late and then remained for a full half-hour, despite numerous attempts to end his session at the pre-scheduled time. He was extremely uncooperative with the evaluation and refused to sign a consent form (irrelevant since the evaluation was court-ordered).

Psychiatric-Legal Questions:

1. Should supervised parenting time between the defendant, Mr. Syphrett, and his two children (V.S., d.o.b. 06/01/09 and B.S., d.o.b. 06/11/07) continue?

2. Should a guardian be appointed for the defendant Mr. Syphrett?

Confidentiality:

Mr. Syphrett was informed that our interview was not confidential and that a report would be submitted to the court. He stated he understood but stated that the fact that the

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evaluation was court-ordered was coercive and that his answers would be different than they would be if he ever sought an evaluation on his own. He clearly knew he was in a court-ordered psychiatric evaluation because he called at 10:30 (for the 10 a.m. appointment) to say he was going to be late because he had to prepare an emergency legal document. He stated he was on his way at that time. He appeared at 11:20, ten minutes prior to the end of our scheduled interview time. Prior to the appointment, he telephoned the office approximately 20 times with demands and questions. Once he appeared, he refused to sign a consent form, which is not technically required. In general, when an individual presents as uncooperative, hostile, or obviously mentally ill, I ask for a consent form to be signed, as an extra measure to protect myself from litigious individuals. In this case Mr. Syphrett refused to sign but his refusal in no way means that I am not permitted to continue with the court-ordered evaluation and document my impressions.

Sources of Information:

1. Clinical interview with Derek Syphrett on 5/16/13 for approximately half an hour (see above)
2. Superior Court of NJ; Chancery Division - Family Part; Mercer County; Docket No. FM-11-97-11 K; Order; Catherine Fitzpatrick, P.J.F.P. (05/08/13)
3. Superior Court of NJ; Chancery Division - Family Part; Mercer County; Docket No. FM-11-97-11 K; Protective Order; Catherine Fitzpatrick, P.J.F.P. (05/09/13)
4. Princeton Medical Group P.A. Medical records for Derek Syphrett; Benjamin Gitterman M.D. (09/08/11, 09/24/09, 06/24/10, 03/11/11)
5. Primary Care Center Hamilton Medical records for Derek Syphrett; Dr. Bob Shaffer (NB: No letterhead, provider's degree, etc. provided and notes are fairly illegible) (dated 6/22/10 and 6/23/10 on different pages)
6. Note from Kim A. Gordon, L.C.S.W. for Derek Syphrett, phone session (09/12/07)
7. Lawrence Memorial Hospital (New London, CT) Pequot Emergency Room records for Benjamin Syphrett (08/13/11)
8. Psychological Evaluation/Parenting Time Risk Assessment; Joseph J. Cooper, Psy.D./J.D. (10/03/11)
9. Communications from Derek Syphrett to Dr. Shnaidman (faxed by Mr. Syphrett) to my office - including copy of Temporary Restraining Order (12/05/12) and Copy of Order of Judge LoBello referring a psychiatric evaluation of 12/04/12 Psychiatric Evaluation which obviously never occurred, and numerous other writings of Mr. Syphrett (received on 05/09/13 and 05/14/12)

Relevant Data:

According to the records listed above, Derek Syphrett and his ex-wife Margaret Wallace have two young children, Benjamin and Vanessa. According to Dr. Cooper's report, the couple separated on or about 06/25/10. The children are in the residential custody of their mother. Mr. Syphrett apparently has supervised visits with his children. Mr. Syphrett has engaged in numerous behaviors which the court, Ms. Wallace, and subsequently Dr. Cooper found troublesome. I will not reiterate them here as undoubtedly the court is extremely familiar with

Mr. Syphrett's often strange interactions with others, his tendency to inundate the court with documents of little clear intention, and the various incidents which Dr. Cooper listed in his extensive report.

INTERVIEW WITH MR. SYPHRETT:

Mr. Syphrett came for his appointment at 11:20 a.m.; he was scheduled for 10 a.m. and called at about 10:30 a.m. to say he was on his way. He lives about 20-30 minutes away from my office with traffic.

Mr. Syphrett says he was considering coming to this appointment but he could not make it on time because he had to file an emergency motion. He says that the evaluation he had with Dr. Cooper was wrong in a number of facts. He goes off on a tangent about the interview with Dr. Cooper who he says told him that his trip to the emergency room with his son was a problem.

He says that his wife was physically abusive to him in front of the children and "had a tantrum over a filing cabinet." He says that he needed to get his birth certificate and marriage license to go to the DMV to renew his driver's license but the mess he might make in the filing cabinet would be worse than whatever would happen to him if he were caught driving without a license. This incident is documented in detail in Dr. Cooper's report and is also not the reason that Mr. Syphrett is here today.

Mr. Syphrett was an extremely poor informant because he would not or could not answer the questions - some he refused to answer, but even when he tried to answer his significant thought disorder, including his disorganized thinking, tangentiality, circumstantiality, paranoia, pressured speech, grandiosity, flight of ideas, loose associations, and other signs and symptoms of psychosis interfered with his ability to cooperate with the interview in a meaningful way.

Past Psychiatric History:

Mr. Syphrett denies any past psychiatric history, with the exception of his evaluations for his legal case. I ask him if he takes any psychotropic medications. He says he was "I was prescribed it once but it was really part of my worker's comp case . . . to use as leverage in a settlement . . ." Again, there is no clear answer. He has been seeing Dr. Benjamin Gitterman at the Princeton Medical Group at least through March of 2011 and obtaining Adderall for his supposed Attention-Deficit Disorder. He told Dr. Cooper that he had "adult ADD." Dr. Cooper points out that Mr. Syphrett would probably not have achieved his highest level of functioning if he truly suffered from Attention-Deficit Disorder. Fifteen to 30 years ago, when Mr. Syphrett was being educated, ADD was not treated as aggressively as it is today, and many bright people can overcome their underlying ADD. However, even if Mr. Syphrett does have some underlying ADD, his current state of mania (see below) precludes any treatment with stimulants. These stimulants are in fact exacerbating Mr. Syphrett's clinical symptoms of mania. Ironically, Dr. Gitterman wrote on 6/24/10 that "The patient is euphoric, has flight of ideas, has thoughts of

grandiosity, has increased activity, is paranoid, has poor insight, exhibits poor judgment, has normal attention span and concentration, has pressured speech, and does not have suicidal ideation." Dr. Gitterman went on to change the Vyvanse (an ADD medication) to Adderall XR (another ADD medication) "due to cost." He diagnosed Mr. Syphrett with "Attn Deficit W Hyperact (31401) but went on to write: "I also suspect Mania. He will see a psychiatrist for an eval." This evaluation apparently never occurred. Dr. Gitterman should have stopped the stimulant at that time.

Mr. Syphrett also saw a social worker (or spoke to her on the phone) in 2007; the note from that session is completely non-contributory as it lacks any of the social worker's impressions of Mr. Syphrett or any description of his presentation, documenting only the content of his communications.

On either 6/22/10 Mr. Syphrett apparently saw Dr. Bob Shaffer, whose credentials are not provided. It is highly unlikely that he is a psychiatrist. I took the liberty of googling this doctor and learned that he does not currently exist. It is unclear if he was an intern or resident but he is most definitely not a psychiatrist anywhere in the United States. Dr. Shaffer continued to see Mr. Syphrett for several weeks, diagnosing him with "Stress at work [leading to] anxiety." He prescribed lorazepam, a tranquilizer (appropriate). The notes are only partially legible but clearly indicate that the next day Mr. Syphrett returned to the clinic after being forcibly removed from his workplace by the police and after threatening his family. Dr. Shaffer subsequently did not document a mental status examination and did not take advantage of this obvious opportunity to hospitalize the patient, instead adding lexapro, an antidepressant (completely inappropriate as it can trigger or worsen mania) to the medication regimen (in addition to the adderall already documented). Mr. Syphrett returned for on follow-up appointment on 7/7/10 at which time Dr. Shaffer wrote "no SSRI" (unclear if he was discontinuing it or merely stating that Mr. Syphrett was not taking it) and referred the patent to follow up with psychiatry, which clearly never happened.

Past Medical History:

Mr. Syphrett refused to discuss his past medical history. The medical notes available state only that he has a history of a knee arthroscopy at some unknown time for some unknown reason.

Medications:

Adderall tab 10 mg po bid ("As prescribed" - by Dr. Gitterman)

Substance Abuse History:

Mr. Syphrett denies the use of any drugs or alcohol and none is documented in the record, although I must point out that his use of adderall is completely inappropriate as will be described below.

guardian ad litem could best represent Mr. Syphrett's interests, taking into account the normal wishes of a non-mentally-ill father for his children. In addition, perhaps this individual, who is there to represent Mr. Syphrett, could assist him in obtaining appropriate psychiatric treatment. Treatment for mania and psychosis has advanced so greatly in recent years that there really is no reason that Mr. Syphrett should not be treated and return to a functional and productive life. He is obviously very intelligent, but he is wasting his intelligence on issues governed by his delusions. I reiterate that he also needs to stop taking the Adderall. I note that Dr. Gitterman's records were released with Mr. Syphrett's permission and there is no HIPPA obstacle toward the court sharing information with Dr. Gitterman! Dr. Shaffer, as well, made a completely erroneous diagnosis based on his patient's complaints without taking into account Mr. Syphrett's mental status examination. This error would be akin to someone telling their doctor that his or her blood pressure is high, and the doctor providing antihypertensive medication without ever measuring the patient's blood pressure.

Overall, I find that Mr. Syphrett is suffering in the current matter, and causing unnecessary suffering to his children, by remaining untreated. If the court could somehow convey this truth to this individual, and if he would accept some treatment, the remainder of these proceedings would likely become moot.

I, Vivian Chern Shnaidman, M.D., being of full age, upon my oath do certify:

1. I am the record keeper for Vivian Chern Shnaidman, M.D. and Jersey Forensic Consulting, LLC.
2. This report concerning Robin Bloom was written in the regular course of business.
3. This report concerning Robin Bloom was made at the time of the condition and/or occurrences reported therein or within a reasonable time thereafter and accurately reflect the condition and/or occurrence.

I certify that the foregoing statements made by me are true. I am aware that, if any of the foregoing statements made by me is willfully false, I am subject to punishment.

Respectfully submitted with a reasonable degree of medical certainty,

Vivian Shnaidman MD

Vivian Shnaidman, M.D.

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childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):

Episodic With Interepisode Residual Symptoms (episodes are defined by the reemergence of prominent psychotic symptoms); also specify if: With Prominent Negative Symptoms

Episodic With No Interepisode Residual Symptoms

Continuous (prominent psychotic symptoms are present throughout the period of observation); also specify if: With Prominent Negative Symptoms

Single Episode In Partial Remission; also specify if: With Prominent Negative Symptoms

Single Episode In Full Remission

Other or Unspecified Pattern

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Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
(1) inflated self-esteem or grandiosity
(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
(3) more talkative than usual or pressure to keep talking
(4) flight of ideas or subjective experience that thoughts are racing
(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
(6) increase in goal-directed activity (either socially, at work or school, or **sexually**) or psychomotor agitation
(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, **sexual indiscretions**, or foolish business investments)
C. The symptoms do not meet criteria for a Mixed Episode.
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

References:

1. http://www.behavenet.com
2. *Diagnostic and Statistical Manual of Mental Disorders Text Revision*, Fourth Edition (DSM-IV TR); American Psychiatric Association; Arlington, VA; 2000
3. Gutheil, Thomas, and Dattilio, Frank. *Forensic Mental Health Testimony*. Philadelphia, PA, Lippincott, Williams, and Wilkins, 2008
4. Kaplan, Benjamin J., MD; Sadock, Virginia A., MD: *Kaplan and Sadock's Comprehensive Textbook of Psychiatry*, Eighth Edition, New York, NY, Lippincott Williams & Wilkins (LWW), 2005

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