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DISTRICT OF COLUMBIA
MARYLAND
NORTH CAROLINA

VIA E-MAIL

December 30, 2019

Paul Pompeo, Esquire
Arnold & Porter Kay Scholer, LLP
601 Massachusetts Avenue, N.W.
Washington, D.C. 20001

Re: Eller v. Prince George's County Public Schools, et al.; 8:18-cv-03649-TDC

Dear Mr. Pompeo:

Enclosed please find Defendants' Fed. R. Civ. P. 26(a)(2) disclosures, which encompass Dr. Cephas' Psychiatric Evaluation Report, the raw data from Ms. Eller's Independent Mental Examination, and Dr. Cephas' CV.

Dr. Cephas has not testified as an expert at trial or by deposition in the previous four (4) years and is being compensated at a rate of $550/hour for the study and testimony in this case.

If you have any questions, please do not hesitate to contact me.

Very truly yours,

James E. McCollum, Jr.

Enclosures

INDEPENDENT MEDICAL EXAMINATION
Jennifer Eller

Examiner: Marcellus R. Cephas M.D., MBA
Diplomat American Board of Psychiatry and Neurology

Eller vs Prince George's County Board of Education
Case No.: 18-cv-03649-TDC/TJS

PSYCHIATRIC EVALUATION

Date of evaluation: November 18, 2019

Ms.Eller was referred by: James E. McCullum, Jr., Amit K. Sharma of McCullum & Associates, LLC

Ms. Eller presented to the office where she was informed that this was an Independent Medical Examination. She consented to this examination. She was informed that this does not constitute treatment nor was this examination confidential. She consented to the examination and showed full understanding of this process.

History of present illness

Jennifer Eller is a 42 year old transgender female that presented to the office for a independent medical examination. She arrived on time with her significant other as well as one of her attorneys.
She was well dressed but appeared anxious initially and later I learned that she has difficulty with strangers as well as being alone with men. She was able to manage her anxiety for this interview.

She stated that she's always known that she is a transgender female but she has had worsening difficulties since 2011. She is a social studies teacher and was working in the Prince George's County School District. She states that in 2011 she was thrust into a hostile work environment after she decided to come out as a transgender female. She states she faced a hostile work environment from the teachers, the principal, the students and the parents. She states this was the worst year of her life. She states she was missed gendered by the student's, teachers, and parents. She felt unsupported and intentionally targeted. When asked for an example of this process she states that during spirit week at the school she was dressed as a twin with another student. She states at that time she was yelled at by the school representative and removed from her classroom. She also gives an example of a student that she caught cheating and when she confronted him she states that she hit her with the door knocking her down. She felt the response from the administration was inadequate. She also gives an example of a time when she was walking to her car and there were students that were standing in the vicinity of her car threatening to rape her. The student she describes as

being 200 to 300 feet away. She determines that the response from the administration was inadequate. The last example that she gives was when she found a note on her car saying that "we kill tranies here." She states that she felt that it was ignored.
She noted that she had been mistreated by the parents of the students and that they made slurs about her. She remembers an occasion when she was having a parent-teacher meeting and the parent walked out. She states that the vice principal was in the meeting when the parent became verbally aggressive and she left the meeting.
She recalls that while walking in the hall she was bumped and that she was called she he, Shim, and that people had threatened to get her fired.
At one point she was in a Bible study group but was informed that she was trying to get the students into a certain lifestyle. The Bible study group stopped.
She recalls making an EEOC complaint and she was transferred to James Madison Middle School. She was there for one year
She states she was asked if it was worth all this just so she could wear women's cloth-ing. She states that she was asked if she had the surgery. She states she was blocked from participating with other teachers

Presently she is working as a program assistant at a school on the military base and she likes her new job, feels comfortable and respected at her new job.
She states that the effect of all this has caused her to be anxious, tense, and in need of muscle relaxants. She also states that she feels watched, judged, stared at, panic and paranoia. She also states she has tachycardia, tremors, apprehension when meeting parents, changes in her ability to converse, lack of openness and feels that she has to hide. She describes this as all being part of the incident that happened in 2011 with the Prince George County School District.

[redacted]

[redacted]

Personal History

She was born in Minnesota to her father Steve and her mother Dawn Marie. Her parents are married and continued to be married to this day. She has a brother who their relationship is strained at present. She states that she was a person that always thought she was a girl. At age 6 she was embarrassed when a teacher told her to get in the boys line when she was standing in the girl's line.
She never was into sports and at times attempted to be, but was stopped by her parents because they did not want her to get hurt. Her father thought that she was gay. She states she was belittled by her father and by her brother. Her mother was much more accepting of her.
She grew up in a good stable home. She attended church groups on Wednesday and was a Methodist.

In 2003 she went on a blind date on the advice of a school advisor. She stated that she did not date in school She was married in 2006. She was married ×5 years.

Her wife had an affair and she sought therapy. The wife continue to have affairs and had multiple affairs. She was told that she needs to be an example to her wife. The wife stated that she wanted her to be more masculine and to do more masculine things for example she would sit down to urinate and the wife would tell her she needed to stand up to urinate. Te wife would buy her masculine shirts and was aggressive towards her always telling her to be masculine. She describes her wife as being domineering and passive-aggressive.
There are no children born to this reunion as she feared that this would be passed on genetically.

[redacted]

Substance Abuse History

[redacted]

Trauma History

2017 she was at a protest at the Whitehouse for the transgender military people when she was pushed down on the street and bruised.

[redacted]

Scales and procedures utilized

1. The Mental Status Examination
2. The MMSE
3. Beck Depression Rating Scale
4. PTSD Symptoms Scale

[redacted]

Mental status exam:

Appearance: She is neat and clean in her appearance, her clothing is organized, no foul odor, colors are matching. Her posture is erect and her gait is steady. She is well groomed

Behavior: She has no psychomotor agitation or retardation. She is able to maintain good eye contact and is calm and cooperative. She is engaging, pleasant and forth-right.

Attitude: She is cooperative, pleasant, relaxed and open. She shows no hostility is able to focus, she is not defensive or evasive.

Level of consciousness: She is alert, She is vigilant and engaging.

Orientation: She is alert and oriented ×4.

Speech and language: She is coherent, talkative, articulate, with normal rate and rhythm and prosody. Her language is fluent and flows without being pressured, mo-notone or soft.

Mood: She describes her mood as being dysthymic and down at times. She has diffi-culty with motivation and energy and often times has the blues.

Affect: Her affect is observed as being appropriate to the situation and consistent with her mood. She is congruent with her thoughts and her description of all events. She at times does appear a little anxious.

Thought process: She is logical, organized, has a elevated flow and is linear in her thought process. She is goal-directed and logical.

Thought content: She does not have any evidence of psychosis such as thought in-sertion, thought broadcasting or ideas of reference. She has no auditory or visual hal-lucinations.

[redacted]

Insight and judgment: She is able to recall events and described them in an organized fashion of why she is here. She understands the consequences and the benefits of her evaluation. She shows good insight and judgment.
Attention: She is able to do digit spans, spelling backwards, calculations (serial 7's)
Memory: She is able to recall recent and remote events. She is able to repeat 3 items that were repeated to him she shows no cognitive impairment or difficulty as reflected by the Mini-Mental Status exam. She is able to recall all pertinent events and times with the dates.
Intellectual ability: She is above average intellect.

Beck Depression Inventory
This is a self-report questionnaire that has 21 questions. This was answered by Ms. Eller and reviewed by the interviewer.
Scores are as follows:
1-10 ups and downs are considered normal
11-16 mild mood disturbances
17-20 borderline clinical depression
21-30 moderate depression
31-40 severe depression
40 extreme depression

[redacted]

PTSD Symptom Scale (PSS)
This is a self-reported questionnaire
She reports that she has not had a [redacted] Her worst recollection of traumatic event is considered to be her hostile work environment. She states she was physically injured by her work environment and that she felt her life was in danger. She also reports that she has been having upsetting thoughts about the events and that her life has changed with these events. It is impacted her work, her household, her friendships, her fun and leisure activities and in general her life.

Documents reviewed
[redacted]

[redacted]

Certified letter from Prince George's County Public schools
This letter was to facilitate a meeting between employee and labor relations. This letter was sent by Angela R Joyner of employee relations.

[redacted]

[redacted]

"Without treatment, gender dysphoric adults experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental health issues. They are frequently socially isolated, as they carry a burden of shame

and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time proves ravaging to healthy personality development and interpersonal relationships (Ettner, 1999; Bockting, 2014). Without treatment, many gender dysphoric people are unable to adequately function in occupational, social or other areas of life."

Dr. Ettner notes by 2011, Ms. Eller was divorced, depressed and anxious, a consequence of her never-ending struggle to resolve her gender issues. In 2011, Ms. Eller sought out a counselor who was knowledgeable about gender issues. [redacted]

The DSM-5 diagnostic criteria for Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

***DSM-5* Criteria for PTSD**

Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B (one required): The traumatic event is persistently re-experienced, in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C (one required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

Criterion D (two required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E (two required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F (required): Symptoms last for more than 1 month.

Criterion G (required): Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H (required): Symptoms are not due to medication, substance use, or other illness.

DSM-5 Criteria for Depression

The individual must be experiencing five or more symptoms during the same 2-week period and at least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
4. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
5. Fatigue or loss of energy nearly every day.
6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
7. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
8. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

These symptoms must cause the individual clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms must also not be a result of substance abuse or another medical condition.

DSM V Criteria for General Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item required in children.
1. Restlessness, feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.

4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another medical disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder)

DSM V Criteria for Borderline Personality Disorder

In the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), BPD is diagnosed on the basis of

A. A marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

1. Frantic efforts to avoid real or imagined abandonment; this does not include suicidal or self-mutilating behavior covered in criterion 5

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3. Markedly and persistently unstable self-image or sense of self

4. Impulsivity in at least two areas that are potentially self-damaging (eg, spending, sex, substance abuse, reckless driving, binge eating) ; this does not include suicidal or self-mutilating behavior covered in criterion 5

5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

6. Affective instability due to a marked reactivity of mood (eg, intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

7. Chronic feelings of emptiness

8. Inappropriate, intense anger or difficulty controlling anger (eg, frequent displays of temper, constant anger, or recurrent physical fights)

9. Transient, stress-related paranoid ideation or severe dissociative symptoms

An alternative model described in DSM-5 for personality disorders includes essential features for personality disorders, with specific features added to denote the specific personality disorder. Essential features of personality disorders using this model include: impairment in self-concept and interpersonal relationships, inflexible traits causing impairment in personal and social situations, and pathological personality traits. Pathological personality traits included in this model are Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism.

Conclusions

Ms. Eeller a 42-year-old female [redacted] This is confirmed by the evaluations and treatment that she has had from multiple providers. However due to the complex nature of her psychological difficulties and various diagnoses of mental illness I will have to address these issues individually.

1. **Gender Dysphoria**
Ms Eller is diagnosed with gender dysphoria with initial onset approximately at the age of 4-6 years old. All providers agree that she meets the criteria for gender dysphoria and she has been treated in accordance with that diagnosis.
In criteria B of gender dysphoria which is a requirement for the diagnosis it states: The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
In Dr. Ettner's evaluation he states: that "people with a diagnosis of gender dysphoria have a varied range of experiences of debilitating psychological symptoms including anxiety and depression. They often times have suicidal ideation and significant mental health issues. They frequently feel defective and developed difficulty with interpersonal relationships. He furthermore states that without treatment gender dysphoric people are usually unable to function adequately in occupational, or social areas of their lives."

This is the experience of Mrs. Eller prior to the incident of 2011. [redacted].

2. **Major Depression**

[redacted]

One significant criteria for major depression states the following: These symptoms must cause the individual clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms must also not be a result of substance abuse or another medical condition. all providers agree that she has had impairment in social, occupational or other important areas of functioning in her life.

[redacted]

3. **Posttraumatic Stress Disorder (PTSD)**

According to the review of documentation there is a diagnosis of PTSD. It is inferred to be secondary to the sustaining traumas that she has experienced from the event of 2011. However, there is significant documentation of multiple events that have transpired in her life as well as the previous mentioned diagnoses that call into question the origin, cause, and the relationship to her work environment.

On the PSS, self report, Ms. Eller notes that she has never had a serious accident or natural disaster. [redacted]. She also notes that she has never had imprisonment, torture or life-threatening event. She describes other trauma as being hostile work environment. She notes that a hostile work environment was the worst trauma that she experienced. [redacted]. She describes herself as being terrified and feeling helpless. she also describes herself as having traumatic thoughts bad dreams of the traumatic event having less interest in participating in important events feeling distanced from people as well as emotionally numb. She has been having difficulty falling asleep feelings of irritability and the highest sense of alertness.

In her personal history she describes the worst incident as being her brother [redacted] causing significant distress in her harassment on Facebook and in other medias about her sexuality. She also describes incidents where she was pushed to the ground by a stranger and felt that her life was threatened.

[redacted]

Criteria H PTSD, which is required, states that the symptoms cannot be cause by another diagnoses or substance abuse. She clearly has several diagnoses that would have to be considered in the differential diagnoses of PTSD.

The diagnoses of PTSD in the documented notes is not clear as to the causality. [redacted] Her clear need for social acceptance as well as the early onset of gender dysphoria makes it imperative to rule out borderline personality disorder vs PTSD.

4. **Borderline Personality Disorder (BPD)**
The majority of cases of BPD begin to occur in early adulthood. The manner in which a person with BPD interacts with others is closely associated with their self-image and early social interactions. BPD causes the following behavioral disturbances:
distorted perceptions
disturbed relationships
excessive emotional responses
harmful, impulsive actions

People with BPD often have a distorted self-image and may feel as though they are flawed and worthless.

People with BPD have problems regulating thoughts, emotions, and self-image. They can be impulsive and reckless, and often have unstable relationships with other people.

We do not know the causes of BPD. Genetics, environmental factors, and brain abnormalities are thought to play a role.
BPD is commonly treated with psychotherapy, (DBT) aided with medication in some cases. Treatment of this disorder is often long and difficult.

It is well documented that she has been treated with a specific type of treatment for BPD.

5. **Hormone Replacement Therapy**

For the treatment of gender dysphoria hormone replacement therapy (HRT) and sexual reassignment surgery (SRS) as well as specific therapy and medication plays significant role on the recovery process.

Ms. Eller is presently prescribed Estrace [redacted]. This is deemed to be medically necessary and appropriate for gender dysphoria. she has been prescribed this regimen since 2011 and presently exhibits secondary sexual characteristics of a female.

The following are significant symptoms of use of Estrace.
Anxiety, depression, nervousness, rash, syncope, weight changes, insomnia, and muscle spasms. There is significant risk of using Estrace, both psychologically and physically. Some these symptoms can be life-threatening.
It is of importance to note that the use of Estrace may cause or contribute significantly to the previous mentioned symptoms of depression, anxiety, and PTSD. This contributes to the significant difficulty and complexity of diagnosing Ms Eller with PTSD caused from a hostile working environment.

It is with medical certainty that Ms. Eller has clear diagnosis of gender dysphoria, depression, anxiety, and symptoms of PTSD. It is clear that the majority of the symptomatology have occurred prior to the event of 2011 where she allegedly experienced a hostile work environment. It is notable that her view of her all work environment contributing significantly to the perception of her safety, mental well being and her self image.

Regards,

Marcellus R. Cephas, M.D. MBA
Diplomat American Board of Psychiatry and Neurology

Mini-Mental State Examination (MMSE)

Patient's Name: Jennifer Ellen Date: 11/18/19

Instructions: Score one point for each correct response within each question or activity.

[redacted]

Interpretation of the MMSE:

Method	Score	Interpretation
Single Cutoff	<24	Abnormal
Range	<21	Increased odds of dementia
	>25	Decreased odds of dementia
Education	21	Abnormal for 8th grade education
	<23	Abnormal for high school education
	<24	Abnormal for college education
Severity	24-30	No cognitive impairment
	18-23	Mild cognitive impairment
	0-17	Severe cognitive impairment

Interpretation of MMSE Scores:

Score	Degree of Impairment	Formal Psychometric Assessment	Day-to-Day Functioning
25-30	Questionably significant	If clinical signs of cognitive impairment are present, formal assessment of cognition may be valuable.	May have clinically significant but mild deficits. Likely to affect only most demanding activities of daily living.
20-25	Mild	Formal assessment may be helpful to better determine pattern and extent of deficits.	Significant effect. May require some supervision, support and assistance.
10-20	Moderate	Formal assessment may be helpful if there are specific clinical indications.	Clear impairment. May require 24-hour supervision.
0-10	Severe	Patient not likely to be testable.	Marked impairment. Likely to require 24-hour supervision and assistance with ADL.

Source:

- Folstein MF, Folstein SE, McHugh PR: "Mini-mental state: A practical method for grading the cognitive state of patients for the clinician." *J Psychiatr Res* 1975;12:189-198.

Close your Eyes.

This is a complete sentence.

THE MENTAL STATUS EXAMINATION

I.	Appearance	(observed)
II.	Behavior	(observed)
III.	Attitude	(observed)
IV.	Level of Consciousness	(observed)
V.	Orientation	(inquired)
VI.	Speech and Language	(observed)
VII.	Mood	(inquired)
VIII.	Affect	(observed)
IX.	Thought Process/Form	(observed/inquired)
X.	Thought Content	(observed/inquired)
XI.	Suicidality and Homicidality	(inquired)
XII.	Insight and Judgment	(observed/inquired)
XIII.	Attention Span	(observed/inquired)
XIV.	Memory	(observed/inquired)
XV.	Intellectual Functioning	(observed/inquired)

Components of the Mental Status Examination

I. Appearance (Observed) - Possible descriptors:

- Gait, posture, clothes, grooming.

II. Behavior (Observed) - Possible descriptors:

- Mannerisms, gestures, psychomotor activity, expression, eye contact, ability to follow commands/requests, compulsions.

III. Attitude (Observed) - Possible descriptors:

- Cooperative, hostile, open, secretive, evasive, suspicious, apathetic, easily distracted, focused, defensive.

IV. Level of Consciousness (Observed) - Possible descriptors:

- Vigilant, alert, drowsy, lethargic, stuporous, asleep, comatose, confused, fluctuating.

V. Orientation (Inquired) – Possible questions for patient:

- "What is your full name?"
- "Where are we at (floor, building, city, county, and state)?"
- "What is the full date today (date, month, year, day of the week, and season of the year)?"
- "How would you describe the situation we are in?"

VI. Speech and Language (Observed)

A. Quantity - Possible descriptors:

- Talkative, spontaneous, expansive, paucity, poverty.

B. Rate - Possible descriptors:

- Fast, slow, normal, pressured.

C. Volume (Tone) - Possible descriptors:

- Loud, soft, monotone, weak, strong.

D. Fluency and Rhythm - Possible descriptors:

- Slurred, clear, with appropriately placed inflections, hesitant, with good articulation, aphasic.

VII. Mood (Inquired): A sustained state of inner feeling – Possible questions for patient:

- "How are your spirits?"
- "How are you feeling?"
- "Have you been discouraged/depressed/low/blue lately?"
- "Have you been energized/elated/high/out of control lately?"
- "Have you been angry/irritable/edgy lately?"

VIII. Affect (Observed): An observed expression of inner feeling. - Possible descriptors:

- Appropriateness to situation, consistency with mood, congruency with thought content.
- Fluctuations: Labile, even.
- Range: Broad, restricted.
- Intensity: Blunted, flat, normal intensity.
- Quality: Sad, angry, hostile, indifferent, euthymic, dysphoric, detached, elated, euphoric, anxious, animated, irritable.

IX. Thought Processes or Thought Form (Inquired/Observed): logic, relevance, organization, flow and coherence of thought in response to general questioning during the interview. - Possible descriptors:

- Linear, goal-directed, circumstantial, tangential, loose associations, incoherent, evasive, racing, blocking, perseveration, neologisms.

X. Thought Content (Inquired/Observed) – Possible questions for patient:

- "What do you think about when you are sad/angry?"
- "What's been on your mind lately?"
- "Do you find yourself ruminating about things?"
- "Are there thoughts or images that you have a really difficult time getting out of your head?"
- "Are you worried/scared/frightened about something or other?"
- "Do you have personal beliefs that are not shared by others?" (Delusions are fixed, false, unshared beliefs.)
- "Do you ever feel detached/removed/changed/different from others around you?"
- "Do things seem unnatural/unreal to you?"
- "What do you think about the reports in papers such as *The National Enquirer*?"
- "Do you think someone or some group intend to harm you in some way?"
- [In response to something the patient says] "What do you think they meant by that?"
- "Does it ever seem like people are stealing your thoughts, or perhaps inserting thoughts into your head? Does it ever seem like your own thoughts are broadcast out loud?"
- "Do you ever see (visual), hear (auditory), smell (olfactory), taste (gustatory), and feel (tactile) things that are not really there, such as voices or visions?" (Hallucinations are false perceptions)
- "Do you sometimes misinterpret real things that are around you, such as muffled noises or shadows?" (Illusions are misinterpreted perceptions)

XI. Suicidality and Homicidality

A. Suicidality – Possible questions for patient:

- "Do you ever feel that life isn't worth living? Or that you would just as soon be dead?"
- "Have you ever thought of doing away with yourself? If so, how?"
- "What would happen after you were dead?"

B. Homicidality – Possible questions for patient:

- "Do you think about hurting others or getting even with people who have wronged you?"
- "Have you had desires to hurt others? If so, how?"

XII. Insight and Judgment (Inquired/Observed) – Possible questions for patient:

- "What brings you here today?"
- "What seems to be the problem?"
- "What do you think is causing your problems?"
- "How do you understand your problems?"
- "How would you describe your role in this situation?"
- "Do you think that these thoughts, moods, perceptions, are abnormal?"
- "How do you plan to get help for this problem?"
- "What will you do when _____ occurs?"
- "How will you manage if _____ happens?"
- "If you found a stamped, addressed envelope on the street, what would you do with it?"
- "If you were in a movie theater and smelled smoke, what would you do?"

XIII. Attention (Inquired/Observed) - Possible descriptors:

- Attend, concentration, distractibility.

A. Digit Span (forward and reverse) - Suggested patient instructions:

- "I will recite a series of numbers to you, and then I will ask you to repeat them to me, first forwards and then backwards." [Begin with 3 numbers – not consecutive numbers, and advance to 7-8 numbered sequence.]

B. Spelling Backwards - Suggested patient instructions:

- "Spell the word 'world.' Now spell the word 'world' backwards."

C. Calculations - Suggested patient instructions:

- (Serial 7's) "Starting with 100, subtract 7 from 100, and then keep subtracting 7 from that number as far as you can go."
- (Serial 3's) "Starting with 20, subtract 3 from 20, and then keep subtracting 3 from that number as far as you can go." [Monitor for speed, accuracy, effort required, and monitor patient reactions to the request]
- "Add these numbers: (15 + 12 + 7)"
- "Multiply these numbers: (25 x 6)"
- "If something costs 78 cents and you give the cashier one dollar, how much change should you get back?"

XIV. Memory (Inquired)

A. Recent Memory – Possible questions for patient:

- "What is my name?"
- "What medications did you take today?"
- "What time was your appointment with me for today?"

B. Remote Memory – Possible questions for patient:

- "Where were you when President Kennedy was shot?" (For patients over 40)
- "What is your Social Security number?"
- "What were the dates of your graduation from high school, college, graduate school?"
- "When and where did you get married?"

C. Immediate Memory (also see XIII.-A. above) and New Learning - Suggested patient instructions:

- "I am going to ask you to remember three words (color, object, animal – e.g., blue, table, and horse) and I will ask you to repeat them to me in 5 minutes. Please repeat them now after me: blue, table, and horse." – 5 minutes elapse – "What were those three words I asked you to remember?" [Monitor accuracy of response, awareness of whether responses are correct, tendency to confabulate or substitute other words, ability to correct themselves with category clue and multiple choice].

XV. Intellectual (Inquired/Observed)

A. Information and Vocabulary - Suggested patient instructions:

- "Name the last 5 presidents." (Clinton, Bush, Reagan, Carter, Ford, Nixon, …)
- "Name 5 of the largest cities in the country." (New York City, Los Angeles, Chicago, Houston, Philadelphia)
- "Name the current president, vice president, governor, and mayor." (Bill Clinton, Al Gore, George Ryan, Richard M. Daley)

B. Vocabulary - Possible descriptors:

- Grade school level, high school level, fluent, consistent with education.

C. Abstraction - Possible questions for patient:

1. Similarities – "How are the following items similar?"
   - "an apple and an orange" (round ~concrete, fruit ~abstract)
   - "a chair and a table" (made of wood ~concrete, furniture ~abstract)
   - "a watch and a ruler" (measurement instruments ~abstract)
2. Proverbs – "How would you describe the meaning of the following sayings?"
   - "People living in glass houses should not throw stones."
   - "A bird in the hand is worth two in the bush."
   - "You shouldn't cry over spilt milk."
   - "Two heads are better than one."

References

Tomb DA. Psychiatry for the House Officer. Williams & Wilkins. (1995).

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). American Psychiatric Association Press. (1994).

Kaplan HI, Saddock BJ. Synopsis of Psychiatry, Eighth Edition, Williams & Wilkins. (1998).

Scully JH. NMS Psychiatry, Third Edition, Williams & Wilkins. (1996).

Endicott J, Spitzer RL. A diagnostic interview: the schedule for affective disorders and schizophrenia. Arch Gen Psychiatry 35:837-844 (1978).

Nurnberger JI Jr, Blehar MC, Kaufmann CA, York-Cooler C, Simpson SG, Harkavy-Friedman J, Severe JB, Malaspina D, Reich T. Diagnostic interview for genetic studies. Rationale, unique features, and training. NIMH Genetics Initiative. Arch Gen Psychiatry 51:849-59 (1994).

THE CAGE SCREENING TOOL

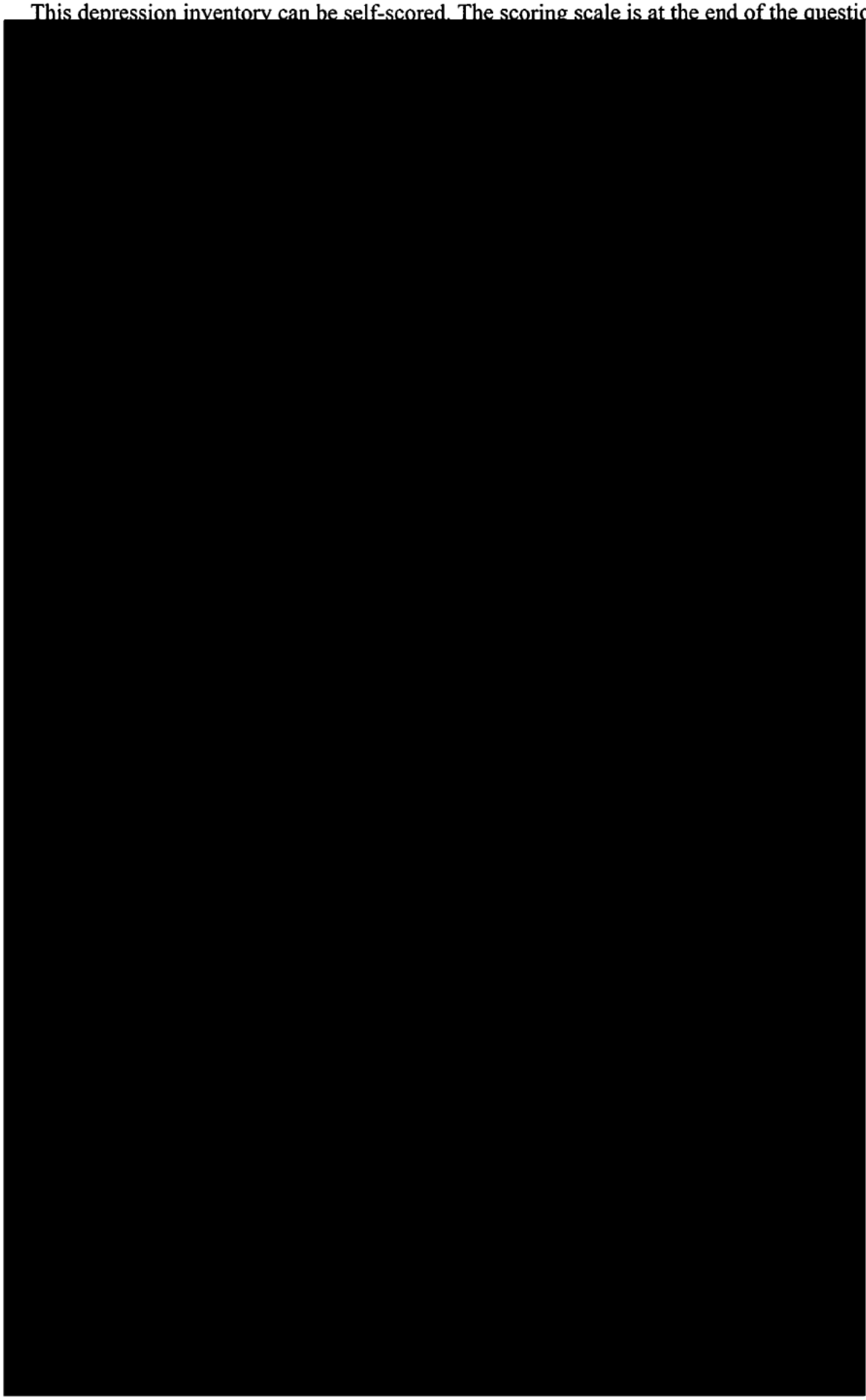
- "Have you ever felt that you should **C**ut down on your drinking?"
- "Have people **A**nnoyed you by criticizing your drinking?"
- "Have you ever felt bad or **G**uilty about your drinking?"
- "Have you ever had a drink first thing in the morning to steady you nerves or get rid of a hangover (**E**ye-opener)?"

- Scoring: Two or more positive responses correlate with substance abuse.

Ewing JA. Detecting alcoholism: The CAGE questionnaire. JAMA 252:1905-1907 (1995)

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.



[redacted]

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

http://www.med.navy.mil/sites/NMCP2/PatientServices/SleepClinicLab/Documents/Beck_Depression_Inventory.pdf

PTSD Symptom Scale (PSS)

Name Jennifer Eller Date 18 Nov, 2019 (Side One)

Below is a list of traumatic events or situations. Please mark YES if you have experienced or witnessed the following events or mark NO if you have not had that experience.

1. Serious accident, fire or explosion	☐ Yes ☒ No
2. Natural disaster (tornado, flood, hurricane, major earthquake)	☐ Yes ☒ No
3. Non-sexual assault by someone you know (physically attacked/injured)	☒ Yes ☐ No
4. Non-sexual assault by a stranger	☒ Yes ☐ No
[redacted]	
6. Sexual assault by a stranger	☐ Yes ☒ No
7. Military combat or a war zone	☐ Yes ☒ No
[redacted]	
9. Imprisonment	☐ Yes ☒ No
10. Torture	☐ Yes ☒ No
11. Life-threatening illness	☐ Yes ☒ No
12. Other traumatic event	☒ Yes ☐ No
13. If "other traumatic event" is checked YES above; please write what the event was	Hostile Environment (work)
14. Of the question to which you answered YES, which was the worst (Please list the question #)	13
15. Which of the above incidences is the reason for which you are currently seeking treatment? (Please list the question #)	13

If you answered **NO** to all of the above questions, **STOP**
If you answered **YES** to any of the above questions, please complete the rest of the form

Please check YES or NO regarding the event listed in question 15.

Were you physically injured?	☒ Yes ☐ No
Was someone else physically injured?	☐ Yes ☒ No
Did you think your life was in danger?	☒ Yes ☐ No
Did you think someone else's life was in danger?	☐ Yes ☒ No
Did you feel helpless?	☒ Yes ☐ No
Did you feel terrified?	☒ Yes ☐ No

Please complete both sides of this document if you answered YES to any of the first series of questions (1-14).

PTSD Symptom Scale (PSS)

(Side 2)

Below is a list of problems that people sometimes have after experiencing a traumatic event. Please rate on a scale from 0-3 how much or how often these following things have occurred to you in the last two weeks:

0 **Not at all**
1 **Once per week or less/ a little bit/ one in a while**
2 **2 to 4 times per week/ somewhat/ half the time**
3 **3 to 5 or more times per week/ very much/ almost always**

[redacted]

Curriculum Vita

MARCELLUS R. CEPHAS, M.D, MBA
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Email: bhi2@mac.com

EDUCATION

Doctor of Medicine 1987
University of Montemorelos Montemorelos, N.L., Mexico

Bachelor of Science Health Science 1983
University of Montemorelos Montemorelos, N.L., Mexico

Master of Business Healthcare Administration 2003
Ana Maria College Paxton, MA

ACADEMIC AND PROFESSIONAL EXPERIENCE

CEO	Behavioral Healthcare of Maryland LLC Executive leadership of the organization Quality assurance and over sight of regulatory compliance 2012-Present
Medical Director Community Recovery Center rome, NY	Rome Memorial Hospital Addictions Medicine 2017-Present
Attending Washington Adventist Hospital	Case load of 15 Acute Psychiatric patients Psychiatric ICU 2014-2019
Medical Director/Chair Attending	Department of Psychiatry Senior Behavioral Health Unit Rome Memorial Hospital Rome New York 2012-Present
Utilization/Disability Determination Physician	Metlife Utilization reviews, Disability Determination. Doctor to Doctor communication and reviews 2011-2013
Medical Director /COO	Behavioral Healthcare Inc. Multi-specialty Group. Washington DC/Maryland Oversight of all operation of multistate clinics. Procurement and implementation of all contracts. Quality assurance and over sight of regulatory compliance 2005-2012
Attending Physician	Rome Memorial Hospital Senior Behavioral Health Unit

Physician for inpatient seniors 65 and above
2003-2012

Medical Director — Peace of Mind Counseling Baltimore MD
Oversight of all clinician and staff
2006-2011

Medical Advisory Board Prince George's County Maryland
Review and determination of Fitness for duty, Disability Retirement, work status for all civil servants of Prince George's County MD
Appointment by Jack Johnson County Executive
2006, 2008, 2010, -2012, Present

President/ Medical Director MRC Behavioral Healthcare Services
Responsible for all operations and clinical services.
2003- Present

Medical Director Behavioral Health Service Washington Adventist Hospital Maryland
Clinical supervision of 40 bed Psychiatric Unit with an 18 bed psychiatric ICU
Partial Hospitalization and Intensive Out patient Program
2002-2003

Medical Director/Chairman of the Dept. of Psychiatry St. Elizabeth's Medical Center Utica NY
Complete and total responsibility for the department of Psychiatry.
Everything from strategic planning for the department to financial forecasting and budgeting. Clinical Instruction for Family practice residents and oversight of their Psych rotations. Extensive experience with the JACHO recertification process.
1997-2003

Oneida County Consulting Physician, Assisted Outpatient Treatment Program Oneida County NY
Evaluate and consult with the commissioner of Mental Health on the implementation of psychiatric patients in the community who were legal committed to the AOTP under Megan's Law in NY. The Psychiatrist responsible for the creation and implementation of the treatment plan of the county for forced medication.
2001-2003

Medical Director, Crisis Evaluation Team Oneida County NY
Supervision of the clinicians and systems of the collaborating hospital for countywide mobile crisis team. This included diversion planning and bed management for the county.

Medical Director, Neighborhood Center Utica NY
Clinic that provides Child and adolescence services.
2001-2003

President/Medical Director New Hartford Psychiatric Services
Psychiatric clinic that provides services to families, adults and adolescence.
Over seeing 5 specialty clinic for the developmentally disable.
1998-present

Medical Director, Adirondack Behavioral Healthcare Network, IPA, LLC
Integral part of the management team that developed and implemented a Behavioral Health Organization that united a consortium of companies fro the sole purpose of responding to the demands of manage care.

1998-2001

Medical Director	H.B. Zachary Company IMSD LaPorte, Texas Responsible for all clinical aspects of IMSD site 8/92 -7/93
Medical Director	H.B. Zachary Company ARCO Chemical Company Responsible for all clinical aspects of site 8/90 8/92
Medical Director/Safety	Pricor of Houston Reintegration Center Houston, Texas Responsible for all clinical aspects of pre-release center Government service 6/88 8/90

Residency

Boston Psychiatric Group	Administrative director responsible for the scheduling and backup of moonlighting residents at The Shattuck Hospital Boston Mass 7/95 -6/97
Psychiatry Resident 4	Chief Resident New England Medical Center/Tuffs University Boston Mass Responsible for all residents' administrative issues. 7/96 -6/97
Psychiatry Resident 2&3	New England Medical Center/Tuffs University Boston Mass 7/94 -6/96
Psychiatry Resident 1	Morehouse School of Medicine Department of Psychiatry Atlanta Georgia 3 mos. Neurology, 6 mos. Medicine, 3 mos. Psychiatry 7/93 -6/94
Internship	University Hospital of Montemorelos Montemorelos, Mexico 3 mos. Obgyn/3 mos. Medicine3 mos. Surgery, ER/3 mos. Pediatrics 6/87 6/88

PROFESSIONAL SERVICE AND AFFILIATION

Elder	Briklow Seventh Day Adventist Church Brinklow MD Present
Member	American Society of Safety Engineers 1993-1994

Member	Texas Rehabilitation Commission 1992-1994
Advisor	CCM (Christian Characters in the Making) 1990-1994
Vice President	ALMAA (Medical Missionary Association) 198-1988
Member	American Psychiatric Association 1994-1998
Board of Directors	South East Kellar Corporation 1992-1995 Nonprofit organization treats, counsels and employs substance abusers and first time offenders).
Secretary	South East Kellar Corporation 1992-1995
Treasurer	Jesus Behind Bars 1992
Director	VOM English Speaking Church 1987-1988
Elder	Belfort SDA Church 1993

Grants

State of Texas, Department of Corrections Treat, lodge, and reintegrate substance abusers which are first time offenders $800,000 (1994)

State of Texas, Department of Corrections Treat, house and rehabilitate substance abusers and first time offenders $187,000 (1993)

City of Houston, Housing Authority to use substance abusers for emergency housing repairs $5,000/house (1990 1994)

Licenses

Certification American Board of Psychiatry and Neurology 2004
Recertification American Board of Psychiatry and Neurology 3/2015
Maryland Medical License #D0059532
New York State Medical License #207888
Massachusetts Medical License #150747
Private Pilots License (80)
Instructor Community CPR Red Cross not current
Instructor SFA Red Cross not current

Presentations

Schizophrenia vs. Delusional Disorder (Case Presentation)
Department of Psychiatry, VAMC
Tuskegee, AL
August 1993

PTSD Diagnosis and Treatment (Case Presentation)
Department of Psychiatry, VAMC
Tuskegee, AL
September 1993

Depression Diagnosis and Treatment in Aphasic Post CVA Patient
Morehouse Department of Psychiatry
November 1993

Sudden Death in OBS Patient (Case Presentation)
Multidisciplinary Morbidity/Mortality Conference, VAMC
Tuskegee, AL
December 1993

HONORS

National Merit Awards in Mathematics

Who's Who of Business Executives 2003

Top Doctor Washington Metropolitan Area 2010

Speaker Bureaus

Bristol Myers Squibb Present
Astrazeneca Present
Eli Lilly 2001
Pfizer 2002
Smithkline Beecham 2002

Reference: Upon request